UNITED STATES DISTRICT COURT
FOR THE SOUTHERN DISTRICT OF FLORIDA

FEDERAL TRADE COMMISSION, Plaintiff, vs. SIMPLE HEALTH PLANS LLC, a Florida limited liability company, et al., Defendants.	**Case No.: 18-cv-62593-DPG**

Plaintiff Federal Trade Commission's Opposition to Defendant Steven Dorfman's Emergency Motion (I) Seeking Confirmation that Scheduling Order is Abated Pending Resolution of the Appeal; (II) to Stay the Proceeding Pending Resolution of the Appeal; or (III) to Expedite Status Conference

I. Introduction

This case involves a health insurance scam that has defrauded at least $150 million from tens of thousands of vulnerable consumers throughout the country. At every turn, its ringleader, Defendant Steven Dorfman ("Dorfman"), has sought to avoid defending on the merits by engaging in a series of procedural maneuvers to delay the preliminary injunction hearing, currently scheduled for April 16. Dorfman's latest ploy is to appeal to the Eleventh Circuit from a non-appealable order of this Court and then seek to indefinitely postpone the April hearing pending months of appellate review on a limited factual record.

Dorfman is wrong that his appeal divests the Court of jurisdiction over this matter. His appeal is improper because his consent to extensions of the Temporary Restraining Order ("TRO") mean the order is still in effect and has not been converted to an appealable preliminary injunction. "[A] temporary restraining order issued or extended with the consent of all parties remains a nonappealable order." *Fernandez-Roque v. Smith*, 671 F.2d 426, 430 (11th Cir. 1982).

Even if Dorfman had filed a proper appeal, the issues raised in his notice of appeal are narrow, and do not affect the Court's ability to adjudicate central issues in this litigation. Dorfman has not challenged the Federal Trade Commission's ("FTC" or "Commission") authority to obtain injunctive relief to halt his illegal conduct, for example, nor has he raised a single question of fact in opposition to the FTC's allegations that he misled consumers. Even if the Eleventh Circuit had jurisdiction over the validity of the asset freeze, this Court may still rule on (1) the Commission's likelihood of success in proving that Dorfman's practices violated the law and (2) the propriety of an injunction against similar misdeeds without impacting the Eleventh Circuit's proceedings at all.

There also is no justification for granting either a full or partial stay of this case pending resolution of Dorfman's appeal. As Dorfman himself acknowledges, one of the requirements for a stay is that he must demonstrate a likelihood of prevailing on the merits of his appeal—an exceedingly *unlikely* prospect. Dorfman's argument that the FTC may not obtain monetary redress for consumers would require a panel of the Eleventh Circuit to overturn decades of settled circuit precedent and deviate from every other appellate court to have ruled on this issue. Dorfman's attempt to address the other factors relevant to weighing the merits of a stay are equally unpersuasive and, in the case of how a stay will affect the public interest, outright offensive. Thousands of Dorfman's victims continue to be charged each month by the third party administrator that issued Defendants' virtually worthless insurance products. Although these consumers likely do not even know they are essentially uninsured and thus are at risk for incurring crippling medical debt due to a serious illness or hospitalization, Dorfman incredibly suggests that these consumers "will not be harmed" during his proposed stay and that the public interest would best be served by allowing him to "focus his limited resources" pursuing his

meritless appeal. This is an especially stunning assertion given the millions of dollars that Dorfman has squandered on private jet travel, luxury sports cars, gambling, and other indulgences with funds derived from the victims of his scheme.

It also is worth noting that the current motion ("Motion to Stay") represents the *fourth time* in as many months[1] that Dorfman has invoked the Court's emergency procedures in filing a motion. In addition to disrupting the Court's ability to manage its schedule, the repeated emergency filings presumably have been designed to attempt to limit the FTC's ability to fully respond. Here, for example, Dorfman delayed the filing of his Motion to Stay for several weeks essentially to manufacture the emergency he now invokes. In requesting the Court's immediate attention, Dorfman even misstates the date on which his brief in opposition to the Court's Order to Show Cause is due, arguing that the March 20, 2019 status conference is too late to provide relief given a March 21, 2019 deadline for filing his brief. In fact, his brief is due four days later, on March 25, 2019,[2] (D.E. 76), not to mention the four and a half months since this case was filed that Dorfman has had to prepare his opposition. The Court should not continue to countenance Dorfman's contrived emergencies.

The FTC submits, as it has consistently throughout this proceeding (except during the government shutdown when it was required to seek a stay) that the preliminary injunction hearing should take place as soon as possible. The FTC is prepared to file its supplemental brief in support of the preliminary injunction pursuant to the schedule set by the Court and to appear at

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[1] One of Dorfman's motions, D.E. 79, was not filed pursuant to Local Rule 7.1(d) but the Court effectively agreed to hear the motion on an emergency basis because Dorfman improperly invoked F.R.C.P. 65(b)(4), which requires a hearing within two days. (*See* FTC's Opp., D.E. 81 at pp. 12-13).

[2] This is an especially conspicuous error given that Dorfman himself proposed and vigorously insisted that the Court adopt the existing briefing schedule. *See* Defense Counsel's February 8, 2019 Email to Chambers, **Exhibit A**.

a hearing at the earliest possible date the Court is available to hear from the parties, if the Court believes that a hearing is even necessary. Dorfman's Motion to Stay should be denied.

II. The Court Should Deny Dorfman's Motion to Stay

a. Dorfman's Improper Appeal Does Not Divest the Court of Jurisdiction

The Court has not been divested of jurisdiction over this matter because Dorfman is attempting to appeal a non-appealable order. It is well settled that, as "a general rule a temporary restraining order is not appealable." *Fernandez-Roque*, 671 F.2d at 429. By the same token, a denial of a motion to dissolve or strike a TRO also is not appealable. It also is clear that the TRO has not been converted into an appealable preliminary injunction here, since it was "extended with [Dorfman's] consent." *Id.* at 430.[3] As the FTC detailed in its opposition to Dorfman's Motion to Strike (D.E. 81), and as the Court held in the February 22 hearing, "any reasonable review of this record indicates that the defendant consented to the extension."[4] Indeed, Dorfman agreed multiple times to an extension until such time as the Court ruled on the preliminary injunction, and in fact on December 19, 2018, asked the district court—over the FTC's objections—to postpone the injunction hearing and to extend the TRO indefinitely until 28 days after he finished his expedited discovery, and no earlier than February 26, 2019. Dorfman also proposed to the Court an April 16 hearing on that preliminary injunction, which the Court

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[3] It is certainly possible that Dorfman's purported withdrawal of consent to the extension of the TRO during the government shutdown and subsequent claim that the TRO was converted to a preliminary injunction was done not just to rush an appeal of legal issues, but also in an effort to avoid full development and analysis of the factual record for the Eleventh Circuit. If Dorfman wants to appeal a preliminary injunction, he should afford the Court the opportunity to hear evidence and rule on one. *See FTC v. Verity Int'l Ltd.*, No. 00-civ-7422, 2000 WL 1805688, at *1 (S.D.N.Y. Dec. 8, 2000) ("Notwithstanding the purported withdrawal of consent, the temporary restraining order remains in effect pending the determination of the motion for a preliminary injunction. Against the possibility that these defendants might contend that the continuation of the restraining order converts it into a preliminary injunction, the Court hereby finds that the Federal Trade Commission has established that it has at least a fair and tenable chance of ultimate success on the merits and that the balance of equities is in its favor.")

[4] Transcript of February 22, 2019 Hearing, **Exhibit B** at 4.

adopted.[5] The Court was right to reject Dorfman's self-serving characterization of the record and gamesmanship in his attempt to avoid litigating the merits of the FTC's claims against him.

Moreover, the issues in the interlocutory appeal are narrow and do not deprive this Court of jurisdiction over the central allegations in the Commission's complaint. As the Eleventh Circuit has held, "an interlocutory appeal does not completely divest the district court of jurisdiction. The district court has authority to proceed forward with portions of the case not related to the claims on appeal . . . ." *Green Leaf Nursery v. E.I. DuPont De Nemours and Co.*, 341 F.3d 1292, 1309 (11th Cir. 2003) (*citing May v. Sheahan*, 226 F.3d 876, 880 n.2 (7th Cir. 2000)). Dorfman identifies three issues that he intends to raise in his purported appeal.[6] Two of those issues relate only to the FTC's authority to seek a limited set of remedies. The third issue is whether the TRO was unlawfully extended by the Court, in spite of Dorfman's repeated requests for and consent to extensions of the TRO. Dorfman did not raise in his motion to dissolve the TRO (or in any other filing) any factual defense to the FTC's claims, and therefore no factual issues will be before the Eleventh Circuit. Dorfman also does not question the FTC's authority to seek a preliminary or permanent injunction that prohibits Defendants from engaging in unlawful conduct in violation of the FTC Act and the Telemarketing Sales Rule.[7] The Court undoubtedly retains its jurisdiction over any dispute about whether such relief is warranted here, particularly given that the other six defendants have not appeared at all. The factual underpinnings of this matter must be litigated regardless of the outcome of the questions raised in Dorfman's interlocutory appeal. If the Eleventh Circuit deems the Court's order reviewable, it

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[5] D.E. 18, 30, 50-1, and 75.

[6] *See* Defendant's Motion to Stay (D.E. 94 at 2).

[7] *See* Defendant Steven Dorfman's Motion to Strike the TRO (D.E. No. 79 at 7-8) ("the plain text of Section 13(b) expressly gives the FTC authority to obtain preliminary and permanent injunctive relief . . . .").

can still consider the issues on appeal while this Court simultaneously proceeds with the litigation without any concern over inconsistent outcomes.

b. Dorfman Has Failed to Establish Any Basis to Stay the Proceeding.

The Eleventh Circuit has described a stay pending appeal as an "extraordinary remedy." *Garcia-Mir v. Meese*, 781 F.2d 1450, 1455 (11th Cir. 1986). The movant bears a "heavy burden" to show he is entitled to this relief. *Jaffe v. Bank of Am., N.A.*, 667 F. Supp. 2d 1299, 1323 (S.D. Fla. 2009) (quoting *Winston Salem/Forsyth Cnty. Bd. of Educ. v. Scott*, 404 U.S. 1221, 1231 (1971)). Dorfman – who ironically filed another emergency motion in January contesting what he dramatically characterized as an "indefinite" stay that could "last for years"[8] – has failed to establish that such a stay is now warranted. Courts consider four factors when determining whether to issue a stay pending appeal: "(1) whether the stay applicant has made a strong showing that he is likely to succeed on the merits; (2) whether the applicant will be irreparably injured absent a stay; (3) whether issuance of the stay will substantially injure the other parties interested in the proceeding; and (4) where the public interest lies." *Hilton v. Braunskill*, 481 U.S. 770, 776 (1987); *Garcia-Mir*, 781 F.2d at 1453. The Eleventh Circuit has held that the first factor is ordinarily "the most important" and requires a determination that the Court's Order was "clearly erroneous." *Garcia-Mir*, 781 F.2d at 1453 (citing *In re Grand Jury Proceedings*, 689 F.2d 1351, 1353 (1982)). Alternatively, the movant may succeed "upon a lesser showing of a 'substantial case on the merits' when 'the balance of the equities [identified in factors 2, 3, and 4] weighs heavily in favor of granting the stay.'" *Id.* (quoting *Ruiz v. Estelle*, 650 F.2d 555, 565 (5th Cir. 1981)). Dorfman does not even attempt to argue that the Court's

[8] As the Court is well aware, the previous stay was triggered by the recent government shutdown and ended weeks—not years—after Dorfman filed his "emergency" motion and after the Court permitted discovery to proceed so that a hearing could be held promptly upon the shutdown's end. (D.E. 68).

ruling was clearly erroneous. Prevailing law and the equities are squarely against him and the Court should deny his motion.[9]

i. Dorfman's argument on appeal directly contradicts decades of settled Eleventh Circuit law and has no chance of success on the merits.

The Court's denial of Dorfman's Motion to Strike the TRO is firmly grounded in Eleventh Circuit precedent. As discussed at length in the FTC's response to that motion (D.E. 81), the Eleventh Circuit and every other circuit that has considered the question (nine in all) have affirmed the FTC's authority to obtain equitable monetary relief in actions brought pursuant to Section 13(b) of the FTC Act. *See FTC v. Gem Merch. Corp.*, 87 F.3d 466, 468-70 (11th Cir. 1996); *FTC v. Commerce Planet, Inc.,* 815 F.3d 593, 598-99 (9th Cir. 2016)*; FTC v. Ross,* 743 F.3d 886, 890-92 (4th Cir. 2014); *FTC v. Bronson Partners*, LLC, 654 F.3d 359, 365 (2d Cir. 2011); *FTC v. Magazine Sols., LLC,* 432 F. App'x 155, 158 n.2 (3d Cir. 2011) (unpublished); *FTC v. Direct Mktg. Concepts, Inc.*, 624 F.3d 1, 15 (1st Cir. 2010*); FTC v. Freecom Commc'ms, Inc.*, 401 F.3d 1192, 1202 n.6 (10th Cir. 2005*)*; *FTC v. Security Rare Coin & Bullion Corp.*, 931 F.2d 1312, 1314-1315 (8th Cir. 1991); *FTC v. Amy Travel Serv., Inc.*, 875 F.2d 564, 571-72 (7th Cir. 1989). As this Court found in denying Dorfman's motion to Strike the TRO at the February 22, 2019 hearing, no subsequent case law has affected the clear Eleventh Circuit law on this point, or the Court's authority to enter the TRO.[10] Even Dorfman acknowledges that the weight of authority is against him and that his argument is "novel." (D.E. 94 at 6). Putting aside the threshold question of whether the appeal is even properly before the Eleventh Circuit, staying this proceeding indefinitely to enable Dorfman to ask the Eleventh Circuit to overturn decades of

[9] Should the Court grant Dorfman's motion for a full or partial stay, the Court should make clear that the terms of the TRO remain in effect during the pendency of the stay to maintain the status quo. Absent such a holding, Dorfman may believe that enforcement of the TRO is stayed and that he is free to ignore its terms by, among other things, dissipating or relocating assets subject to the TRO's asset freeze.

[10] Transcript of February 22, 2019 Hearing, **Exhibit B** at 4 ("I find that I had authority to enter the TRO, and I don't think any of the cases suggest that I could not.").

precedent based on a novel argument is simply not justified. This is especially true in light of the significant ongoing harm to consumers discussed below.

ii. Dorfman will not suffer irreparable damage absent a stay.

Absent a stay, Dorfman will be forced to confront the FTC's overwhelming evidence of his law violations, but that is not an irreparable injury as contemplated by this inquiry. Dorfman complains about the cost of defending against the FTC's claims, but in his desperation to avoid defending on the merits, Dorfman conveniently ignores that this Court must rule on whether to issue a preliminary injunction *regardless of the issues on appeal*. In entering the TRO, this Court found good cause to believe that, among other things, Defendants have, in numerous instances, sold limited benefit plans and medical discount memberships to consumers by misrepresenting that such products are comprehensive health insurance or the equivalent, in violation of the FTC Act and the Telemarketing Sales Rule. (D.E. 15). The Court will determine whether there is cause to enter a preliminary injunction barring all Defendants – including the six corporate defendants who are not parties to the appeal – from engaging in deceptive business practices regardless of what the Court of Appeals may say about the FTC's authority to obtain equitable monetary relief, or when it says it. Dorfman has not presented any facts to refute the FTC's strong evidence in support of such an injunction, and expenditures related to that inevitable adjudication do not amount to irreparable injury. "[L]itigation expense, even substantial and unrecoupable cost, does not constitute irreparable injury." *FTC v. Standard Oil Co. of Cal.*, 449 U.S. 232, 244 (1980).

Moreover, the record in this litigation belies any suggestion that Dorfman is concerned about litigation costs. For instance, he has insisted that his defense at this preliminary stage requires extensive third party discovery. To that end, he fought aggressively to obtain the FTC's

undercover identities, claiming that he needed this information to conduct that broad third party discovery.[11] Five weeks later, Dorfman has yet to serve any third party discovery.[12] If Dorfman were concerned about runaway legal expenses, he would have proceeded quickly to a preliminary injunction hearing and made his legal arguments there, followed by an appeal if necessary. Instead, Dorfman has tried to short circuit the Court's ability to consider a full factual record and to make factual findings against him.

Dorfman also cannot reconcile his argument that he will be irreparably harmed without a stay with the position he previously took in two motions, resulting in two hearings, in which he argued that the TRO was improperly extended. With his current emergency motion, Dorfman seems to seek the very thing he has argued is unlawful—to stay the case, thereby extending the TRO at a minimum for months. Whether Dorfman is outraged by an extension of the TRO or not, one thing is certain: any harm he suffers as a result of the preliminary injunction hearing proceeding on schedule is a result of his own unlawful conduct, nothing more.

iii. The FTC and the public interest will suffer irreparable damage if this case is stayed.

The FTC's interest and the public interest are one in the same. One of the FTC's core missions is to protect consumers from fraud, and in filing this case, the FTC's goal is to stop the fraud and to return as much money as possible to Dorfman's victims. The fraud uncovered in this case is especially vast and egregious. It is difficult to overstate the devastating and irreparable impact Dorfman's scam has had and continues to have on its victims.

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[11] Transcript of February 6, 2019 Hearing Before Judge Seltzer, **Exhibit C** at 3 ("I need to be able to take that information and go out into the marketplace and make sure I am doing everything I can to develop third-party evidence that I can use to cross-examine that person with those characteristics").

[12] The FTC has not received any notice regarding the service of any third-party subpoenas as required by Fed. R. Civ. P. 45.

In support of its motion for TRO, the FTC presented overwhelming evidence that Defendants deceived consumers into purchasing what they believed was comprehensive health insurance, and that consumers often do not discover the truth about what they purchased until they try to use their plan, at which point it typically is too late. Many times, Dorfman's fraud has caused these consumers to be left with tens, or hundreds, of thousands of dollars in medical bills. The evidence of the fraud and the impact on its victims has increased exponentially since the entry of the TRO. Defendants' own records reveal thousands of stories of consumers who have been left by Defendants' deception with staggering medical bills. In other instances, necessary treatment or medication was denied to these consumers.[13] A small sampling of consumer complaints (out of hundreds) that state insurance regulators forwarded to Defendants illustrates the hardship suffered by Dorfman's victims.[14] These consumers: 1) were blatantly misled into thinking these plans were comprehensive health insurance plans with broad coverage;[15] 2) missed open enrollment and were left uncovered despite having major medical needs, and were subject to the tax penalty;[16] 3) had or developed serious health issues while essentially uninsured;[17] 4) were left with crippling medical bills, ruined credit, and/or fighting with

[13] Defendants kept hundreds of thousands of sales and customer service call recordings that capture the lies Defendants fed to consumers, and the frustration and desperation experienced by consumers after learning the truth.

[14] *See* Al-Najjar Declaration, **Exhibit D, Attachment A.**

[15] *See id.* at 1 (thought he was talking to Blue Cross Blue Shield); 11 (better than traditional insurance); 15 (would cover diabetes treatment); 29 (only will have co-pays); 35 (a PPO); 38 (a 70/30 plan, with set costs for services and prescriptions); 44 (ER visits covered); 52 (a comprehensive plan to cover cancer treatment); 55 (70% of hospital visits covered, no tax penalty); 66 (identical to Blue Cross Blue Shield plan); 72 (better than a Blue Cross Blue Shield plan); 75 (70/30 plan).

[16] *See id.* at 1, 5, 8, 11, 16, 60, and 71.

[17] *See id.* at 4 (emergency heart operation); 8 (kidney damage, dialysis, possible transplant); 11 (ER visits for wife and daughter); 15 (diabetes and related hospital stays); 19 (pregnancy); 22 (appendix removal); 25 (heart procedure); 28 (pain management); 48 (13 prescriptions); 52 (cancer); 63 (emergency bypass); 66 (broken toe, kidney stone); 75 (heart issues, related hospitalization).

collection agencies;[18] and 5) found themselves in a frustrating, endless loop of call transfers from one unhelpful representative to another trying to determine what coverage they have.[19] Defendants respond to consumers' heartbreaking accounts with essentially a form letter denying any wrongdoing.[20]

Critically, thousands of Dorfman's victims continue to be charged every month and do not yet even know they are uninsured. Dorfman's third party administrator, Health Insurance Innovations ("HII"), is the entity that collects payments from consumers who purchased plans through Defendants, and HII continues to charge consumers despite the TRO. From December 2018 through February 2019, HII has charged consumers 165,798 times, totaling approximately $14.6 million, which has resulted in commission payments owed to Defendants of approximately $4.6 million.[21] The Receiver is still only temporary under the TRO, which limits his ability to effectively carry out his duties, including addressing the situation with HII's continued billing of consumers who were victims of Defendants' deceptive sales pitches.[22] The FTC continues to believe, as it argued in opposition to Dorfman's second attempt to extend the TRO in December 2018 (D.E. 52), that these consumers need to be notified and given an opportunity to cancel.

Moreover, every day of delay in this case unnecessarily depletes the funds that will be available to consumer victims at the end of the litigation. Until the preliminary injunction is entered, Dorfman continues to receive $5,000 every month from the frozen funds for his living expenses. (D.E. 48). Dorfman also is depleting the assets in the Receivership Estate. For the

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[18] *See id.* at 5 ($110,380.85); 16 ($53,000); 22 ($26,000, more money than he makes in one year); 25 ($92,000); 28 ($5,888.89); 32 ($13,347); 45 ($8,359.12); 52 ($20,000); 63 ($350,000, consumer is retired); 66 ($17,000); 75 ($53,920, with more bills coming in).
[19] *See id.* at 11 (called 18-19 times); 19 (called over 25 doctors trying to find coverage); 41 (called numerous times, bounced around, on hold for hours, unable to get answers for months); 60 (transferred all around, different people giving different answers); 75 (same).
[20] *See id.* at 2, 6, 9, 13, 17, 20, 23, 26, 30, 33, 36, 39, 42, 46, 50, 53, 61, 64, 68, 73, and 76.
[21] *See* Al-Najjar Declaration, **Exhibit D** at ¶¶ 5-7.
[22] *See, e.g.*, D.E. 73 at 3-6.

past several months, Dorfman has served the Receiver with numerous vague and extremely broad demands that have required the Receiver, counsel for the Receiver, and his staff to incur extraordinary costs searching for and copying records for Dorfman.[23] Rather than simply obtaining records directly from the business, as the TRO affords him the opportunity to do, Dorfman has attempted to shift the cost and burden of engaging in this "discovery" onto the Receiver. Four and a half months after the Receiver first told Dorfman he was welcome to come to the premises to copy any records he needs for his defense, Dorfman still has not done so.[24]

At the time of filing, the total assets frozen in the Receivership estate and Dorfman's accounts totaled only approximately $4 million, which is a miniscule fraction of the total financial injury consumers suffered. Of course, that amount has already been depleted in the ensuing months. Defendants earned at least $150 million in commissions alone from their deceptive scheme; there is no question consumers suffered hundreds of millions more in harm.

Dorfman's callous argument that the public interest favors a stay is consistent with his business practices, showing little regard for the harm he has done to consumers. Each day of delay represents additional consumer harm and a depletion of the assets ultimately available to redress those harms. This factor clearly supports moving forward with the preliminary injunction proceedings.

III. This Court Should Rule on its Order to Show Cause Why a Preliminary Injunction Should Not Issue on the Papers

In its TRO ruling on October 31, 2018, the Court ordered Defendants to show cause why a preliminary injunction should not issue. The six corporate defendants are unrepresented and have not appeared or responded. Four and a half months into this litigation, Dorfman continues to attempt to delay adjudication of the facts in this case, and now seeks to deprive the Eleventh

[23] D.E. 73 at 6-10.
[24] *See id.*

Circuit of an opportunity to review a full factual record. Dorfman thus far has not presented any evidence to dispute the entry of a preliminary injunction and appears to be making purely legal arguments to contest the TRO and entry of the preliminary injunction. The FTC proposes that rather than continue to delay this matter indefinitely, as Dorfman suggests, the Court should rule on the preliminary injunction expeditiously at the close of briefing, based upon the filings before it. In its TRO, this Court ordered that "[a]n evidentiary hearing on Plaintiff's request for a preliminary injunction is not necessary unless Defendants demonstrate that they have, and intend to introduce evidence that raises a genuine issue of material fact." (D.E. 15 at 29). Given that Dorfman has not presented any disputed fact or any indication that his defense will involve genuine issues of material fact,[25] and his defense appears to be purely legal, the Court need not delay its consideration of this matter for a hearing.

IV. Dorfman Has Abused Local Rule 7.1(d) Regarding Emergency Motions

In filing this Motion to Stay as an emergency, Defendant has violated Local Rule 7.1(d) and shown no regard for the Court's limited time and resources. Local Rule 7.1(d) provides that motions "are not considered emergencies if the urgency arises because of the attorney's or the party's own dilatory conduct. Generally, unless a motion will become moot if not ruled on within seven (7) days, the motion should not be filed as an emergency motion." To the extent this motion is in any way an emergency, it is one of Dorfman's own making.

First, Dorfman announced his intent to appeal the Court's ruling on his Motion to Strike the TRO during the February 22, 2019 hearing–more than a month before his brief in opposition

[25] To the extent Dorfman argues that Defendants' "verification recordings" and documents with disclaimers provided to consumers after the sale are evidence that they did not violate the law, this does not create a genuine issue of fact requiring a hearing. Under the law, the sham verifications and belated discosures are legally insignificant. *See FTC v. IAB Mktg. Assoc., LP*, 746 F.3d 1228, 1233 (11th Cir. 2014) (*caveat emptor* is not a valid defense to liability arising from misrepresentations.); *FTC v. World Patent Mktg., Inc.*, No. 17-cv-20848, 2017 WL 3508639, at *13 (S.D. Fla. Aug. 16, 2017) (same).

to the preliminary injunction was due. Then, on February 28, 2019, in an email to the FTC, his counsel again indicated their intent to file a notice of appeal, along with a motion to stay the proceedings, and a request to expedite the preliminary injunction proceedings, as the Court had offered to do.[26] The FTC responded to that email on March 1, 2019–more than three weeks before Dorfman's brief was due–indicating it opposed a stay, but would agree to an earlier adjudication of the preliminary injunction.[27] Counsel for Dorfman did not respond to the FTC's email, or attempt to contact the FTC prior to filing their oblique Request for Status Conference on March 11, 2019, which was a week after Dorfman filed his notice of appeal and still two weeks before his brief was due. (D.E. 91). Even when he finally filed the Motion to Stay on March 15, 2019, Dorfman had ten days before his brief was due on March 25.

Dorfman appears to have deliberately delayed filing both his Notice of Appeal and the current motion, forcing the FTC again to respond on an expedited basis rather than pursuant to a usual briefing schedule.[28] Dorfman has known about the current preliminary injunction briefing schedule since February 8, 2019, when the Court entered it. Dorfman's failure to file his Notice of Appeal and Motion to Stay earlier, before his response to the Court's Order to Show Cause was imminently due, at best shows a troubling lack of diligence and, at worst, represents total disregard for the Court's schedule and usual procedures. Dorfman has not demonstrated that a true emergency exists, and in fact exaggerated the need for the Court's immediate attention by misstating that his brief is due four days earlier than it actually is. Local Rule 7.1(d) exists to ensure that emergency motions are "true emergencies" and, as Dorfman's counsel himself

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[26] **Exhibit E** at 1-2; **Exhibit B** at 6.
[27] **Exhibit E** at 1.
[28] Dorfman actually appears to have attempted to deprive the FTC of an opportunity to meaningfully respond or prepare for a discussion of this issue at all, having first – without notice to the FTC – filed the cryptic request for a status conference. (D.E. 91).

acknowledged in his certification of emergency, the Rule provides that "unwarranted certification of may lead to sanctions."

V. Conclusion

For the reasons discussed above, the FTC requests that the Court deny Dorfman's Motion to Stay, keep the current briefing schedule on its order to show cause why a preliminary injunction should not issue, and rule on the papers.

Dated: March 18, 2019

Respectfully submitted,

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CERTIFICATE OF SERVICE

I HEREBY CERTIFY that a true and correct copy of the foregoing was served on March 18, 2019, by the Notice of Electronic Filing, and was electronically filed with the Court via the CM/ECF system, which generates a notice of filing to all counsel of record.

/s/ Elizabeth C. Scott
Elizabeth C. Scott (SBA # A5501502)

From:	Gershoni, Elan
To:	gayles@flsd.uscourts.gov
Cc:	O"Quinn, Ryan; Rodriguez, Javier; Wei, Joannie; Davis, James; Scott, Elizabeth C.; michael.goldberg@akerman.com; naim.surgeon@akerman.com
Subject:	FTC v. Simple Health et al., Case No. 18-cv-62593; Proposed Scheduling Order for Preliminary Injunction
Date:	Friday, February 08, 2019 2:38:26 PM
Attachments:	190208 - Proposed Scheduling Order (Scenario 1).DOCX 190208 - Proposed Scheduling Order (Scenario 2).DOCX

Dear Judge Gayles,

On February 5, 2019, the Court entered an endorsed order requiring the parties to submit a joint proposed briefing and hearing schedule for the preliminary injunction [D.E. 71]. Mr. Dorfman made a good faith effort to negotiate the proposed deadlines, but, unfortunately, the parties have reached an impasse.

The FTC requested that the preliminary injunction hearing be held on a date on or after April 8, 2019. This morning, your chambers advised that the first available dates for the preliminary injunction hearing consistent with the FTC's requested hearing date are April 16, 2019 and April 19, 2019. Either date works for Mr. Dorfman and the FTC indicated that it prefers to have the hearing on April 16, 2019.

Based on the available dates, Mr. Dorfman proposed the following alternative briefing and hearing schedules to the FTC:

1. **Scenario 1:**
    a. Preliminary Injunction Hearing: April 16, 2019.
    b. Mr. Dorfman's Response Deadline: March 25, 2019.
    c. FTC's Reply Deadline: April 8, 2019.
2. **Scenario 2**:
    a. Preliminary Injunction Hearing: April 16, 2019.
    b. Mr. Dorfman's Response Deadline: 5 business days before the Preliminary Injunction Hearing (i.e., April 9, 2019).
    c. FTC's Reply Deadline: 1 business day before the Preliminary Injunction Hearing (i.e., April 15, 2019).

Either of Mr. Dorfman's proposed schedules provide both parties sufficient time to prepare for the hearing and review and incorporate the discovery and related documents produced by the FTC and third parties, including discovery that the FTC only produced to Mr. Dorfman today relating to the FTC's undercover agents – it will take time to identify and obtain additional related documents and information due to the fact that the defendants' server and documents are longer in their possession. Furthermore, the second proposed schedule mirrors the exact deadlines that the FTC proposed and which were approved by the Court in its *ex parte* Temporary Restraining Order. *See* ECF 3-1 and ECF 13 at Sections XXV and XXVI.

While Mr. Dorfman prefers the second proposed schedule that mirrors the deadlines that the Court previously approved, he is amenable to either. Unfortunately, the FTC does not consent to either of

the proposed schedules, including the schedule it proposed at the outset of this case. Instead, the FTC insists that Mr. Dorfman's response deadline be set at March 8, 2019. However, the FTC has not articulated a reason to Mr. Dorfman as to why he should be required to submit his responsive brief 6 weeks in advance of the preliminary injunction hearing. This deadline is unnecessarily short, especially in light of the facts that Mr. Dorfman only received discovery from the FTC today and neither of his proposed briefing schedules will prejudice the FTC (as evidenced by the FTC's agreement to those deadlines at the outset of this case). Indeed, the FTC's proposed deadline will only serve to prejudice Mr. Dorfman.

Based on the foregoing, Mr. Dorfman respectfully requests that the Court enter one of the attached proposed scheduling orders. Thank you.

Sincerely,

Elan A. Gershoni

T +1 305.423.8567
F +1 305.675.0527
E elan.gershoni@dlapiper.com

DLA PIPER

DLA Piper LLP (US)
200 South Biscayne Boulevard, Suite 2500
Miami, FL 33131-5341
United States
www.dlapiper.com

UNITED STATES DISTRICT COURT
SOUTHERN DISTRICT OF FLORIDA
MIAMI DIVISION
CASE NO. 18-CV-62593

FEDERAL TRADE COMMISSION,

Plaintiff,

vs.

SIMPLE HEALTH PLANS, LLC, et al

Defendant.

Miami, Florida

February 22, 2019

10:30 a.m. to 11:20 a.m.

Pages 1 to 42

MOTION HEARING
BEFORE THE HONORABLE DARRIN P. GAYLES
UNITED STATES DISTRICT JUDGE

APPEARANCES:

FOR THE PLAINTIFF:
ELIZABETH C. SCOTT, ESQ.
JOANNI WEI, ESQ.
U.S. FEDERAL TRADE COMMISSION
MIDWEST REGION
230 S. Dearborn Street, Suite 3030
Chicago, Illinois 60604

FOR THE DEFENDANTS:
RYAN D. O'QUINN, ESQ.
ELAN GERSHONI, ESQ.
DLA PIPER LLP
200 S. Biscayne Boulevard
Suite 2500
Miami, Florida 33131

FOR THE RECEIVER:
NAIM SURGEON, ESQ.
AKERMAN LLP
350 East Las Olas Boulevard
Fort Lauderdale, Florida 33301

RECEIVER: MICHAEL GOLDBERG, ESQ.
AKERMAN LLP
350 East Las Olas Boulevard
Fort Lauderdale, Florida 33301

STENOGRAPHICALLY REPORTED BY:

PATRICIA DIAZ, FCRR, RPR, FPR
Official Court Reporter
United States District Court
400 North Miami Avenue
11th Floor
Miami, Florida 33128
(305) 523-5178

THE COURT: Hold on.

Look, there is one attorney for either side. We can't keep having the back and forth. So, Ms. Scott, I will let you have the last word but this is it. I mean --

MS. SCOTT: Okay. Thank you, Your Honor.

THE COURT: Go ahead.

MS. SCOTT: The one final point I wanted to make about the temporary restraining order is that it's also an order to show cause and it orders the defendant to show cause why the preliminary injunction should not be entered.

There has been no factual defense at all, you know -- there has been no -- it's not contested the voluminous evidence that we produced and provided to support the TRO and, you know, we would invite the Court to enter the preliminary injunction on the basis of the evidence that has been previously submitted.

THE COURT: Okay.

MR. O'QUINN: Your Honor, may I please approach and hand you a copy of the e-mail that I made reference to during my presentation that contains our expressed reservation in connection with --

THE COURT: I mean, I accept your word. Anything else by way of argument?

MR. O'QUINN: No, Your Honor.

THE COURT: All right. The motion is denied.

I find that I had authority to enter the TRO, and I don't think any of the cases suggest that I could not.

And regarding the issue of consent, under Rule 65 the Court can extend the period if the Court finds that there is good cause or the party consents. I mean, any reasonable review of this record indicates that the defendant consented to the extension. It wanted discovery. The only time that the defendant objected was when there was a government shutdown for which the Court found there was good cause under the circumstances.

I will issue an order but I think the parties should have a ruling now. I am not going to direct the receiver to represent your interest on appeal but if you want an earlier hearing, I will give it to you. You don't have to wait until July if that's what you want.

MR. O'QUINN: Your Honor, we will review the evidence and then make a filing with the Court.

THE COURT: Okay. Anything you want to add, Mr. Surgeon?

I don't know if Mr. Goldberg is still on the phone.

MR. SURGEON: Nothing from me, Your Honor.

MR. GOLDBERG: Nothing from me, Your Honor.

THE COURT: There was one thing that was discussed in the receiver's interim status report. There are leases for which no business is being conducted. Why is the defendant not

issue so you don't necessarily want to consent to it but is there something else you need to see before I make a decision on this?

MR. O'QUINN: No, Your Honor. I appreciate you affording me that. I am not trying to be cute with the Court. It's just by way of example, the Court asked us to give dates for a hearing. The FTC insisted on April and now there has been an argument that I somehow consented to a TRO extension. I don't want to have the consent that I give in connection with a business lease to be revisited to mean later as having consented or waived some right where --

THE COURT: I think you just made the point on the record.

Mr. Surgeon, is there something you want to say?

MR. SURGEON: Your Honor, I was just going to point out that with respect to Mr. O'Quinn saying he does not want to consent, we are fine with that. I think the issue is we hadn't heard anything, either yay or nay.

Then with respect to the concerns about the business, that's a little unclear to us because as the Court is aware, with HII's termination of its relationship with Simple Health, there is, in fact, no business at this time.

THE COURT: So my suggestion to the receiver is you submit a proposed order regarding this issue. We have heard from Mr. O'Quinn on the record, and I understand his objection

but I think that's probably the best course to take.

Okay. Again, as I indicated before, the Court has found good cause to continue the TRO so that the defendant could get the discovery that he wanted to prepare for the hearing. We had a date and then we had a government shutdown and under those circumstances of the shutdown I found good cause to continue the hearing.

There is still this discovery issue, receiving discovery, for which I still find good cause to continue the hearing but, again, I just want to make it clear, there is a period of time in March that I am out of the district but if you want an earlier date, you are being afforded that opportunity.

All right. Anything else for the FTC, Ms. Scott?

MS. SCOTT: No, Your Honor. Thank you.

THE COURT: Anything else, Mr. Goldberg?

MR. GOLDBERG: No, thank you, Your Honor.

THE COURT: Anything else, Mr. O'Quinn?

MR. O'QUINN: No, Your Honor, thank you.

THE COURT: You dropped something here.

MR. O'QUINN: Yes, I am going back up and pick that up now.

THE COURT: All right. We will be in recess.

COURT SECURITY OFFICER: All rise.

MR. O'QUINN: Have a good weekend.

IN THE UNITED STATES DISTRICT COURT
FOR THE SOUTHERN DISTRICT OF FLORIDA
FORT LAUDERDALE DIVISION
CASE NO. 18-cv-62593-DPG

FEDERAL TRADE COMMISSION,

Plaintiff,

vs.

SIMPLE HEALTH PLANS, LLC., et al,

Defendants.

Wednesday, February 6, 2019
2:04 p.m.
Fort Lauderdale, Florida

Pages 1 through 47

TRANSCRIPT OF DISCOVERY HEARING
BEFORE THE HONORABLE BARRY S. SELTZER
UNITED STATES MAGISTRATE JUDGE

APPEARANCES:

For the Plaintiff:
(by telephone) Joannie Wei, Esq.
(by telephone) James Davis, Esq.

For the Defendants: Ryan Dwight O'Quinn, Esq.
Elan Abraham Gershoni, Esq.

Transcribed By: Judith M. Wolff, CRR
judmwolff@hotmail.com

TRANSCRIBED FROM DIGITALLY-RECORDED AUDIO

--

THE COURT: Okay. So tell me how you would be limited, then.

MR. O'QUINN: So, for instance, this is a characteristic of a witness that I think is a material part of a witness. So me being able to sit down with my client and being able to say let's listen to the three people who are presenting themselves as customers. Tell me what's atypical about this communication.

Why -- you know, what is it about this that would help me to cross-examine this witness? This person is going to testify. I would imagine I will be able to play the tape.

THE COURT: Okay. Why do you need the name John Doe to be able to ask your client those questions?

MR. O'QUINN: I would need to be able to have him listen to tapes --

THE COURT: All right. All right. Okay. But why do you need the name of the name John Doe to ask your client that question?

MR. O'QUINN: I don't necessarily need the specific name John Doe to ask my client that question.

THE COURT: Okay. Tell me why you need the name John Doe to effectively prepare your defense with your client.

MR. O'QUINN: Sure. Well, there are two reasons, your Honor.

THE COURT: Okay.

MR. O'QUINN: One is I need to be able to take that information and go out into the marketplace and make sure I am doing everything I can to develop third-party evidence that I can use to cross-examine that person with those characteristics.

THE COURT: I thought you just told me that you would be able to do that anyway?

MR. O'QUINN: I told you it's unclear to me what the FTC's position is on that.

THE COURT: Okay. Well, I'll ask, in a moment I'll ask Ms. Wei about that.

MR. O'QUINN: And the second reason is because I fundamentally believe that it is a difficult position where there is information that the FTC does not want me to share with my client.

I know of no reason why I can't discuss information with my client. And I don't want to find myself in front of this Court or Judge Gayles having to try to discuss what I did or didn't discuss with my client --

THE COURT: But you're not answering my question.

What does the AKA add to your ability to prepare your client?

MR. O'QUINN: Your Honor, it's hard for me to give you a fine point on that because I'm not in the process of

SUPPLEMENTAL DECLARATION OF NATHANIEL AL-NAJJAR PURSUANT TO 28 U.S.C. § 1746

I, Nathaniel Al-Najjar, hereby declare as follows:

1. My name is Nathaniel Al-Najjar. I am a United States citizen and over eighteen years of age. I am employed as a paralegal with the Federal Trade Commission ("FTC" or "Commission"), a position that I have held for approximately 2 years. My office address is 230 South Dearborn Street, Room 3030, Chicago, IL 60604. I have personal knowledge of the facts stated in this declaration, and if called as a witness, I would testify to the same.

2. As part of my duties, I research, monitor, and investigate parties who are suspected of engaging in deceptive or unfair acts or practices in violation of Section 5(a) of the Federal Trade Commission Act, and other laws or rules enforced by the FTC, including the Telemarketing Act, and the Telemarketing Sales Rule. I also gather information and review documents, financial records, and other evidence in connection with FTC investigations and federal court litigation. In the course of my employment, I have participated in the investigation of, and litigation against, Simple Health Plans LLC, Health Benefits One LLC, Health Center Management LLC, Innovative Customer Care LLC, Simple Insurance Leads LLC, Senior Benefits One LLC, and Steven J. Dorfman (collectively, "Defendants"). I previously submitted a declaration in this matter, which I executed on October 17, 2018. I have acquired personal knowledge and information about the facts stated herein, and, if called, would testify to the same.

3. Some information that constitutes or would reveal personally identifiable information or sensitive health information has been redacted from several attachments to this declaration.

DEPARTMENT OF INSURANCE COMPLAINTS

4. Pursuant to provisions of the Temporary Restraining Order entered by the Court on October 31, 2018, FTC staff inspected and copied paper and electronically stored business records maintained by Defendants at their business locations and at an offsite data center. Included in the electronically stored information on Defendants' servers were hundreds of

complaints sent by consumers to various state Departments of Insurance (or state government entities with equivalent jurisdiction over the insurance industry), which were then forwarded to Defendants. The complaints were grouped in folders containing the initial complaint and attachments to the complaint, relevant correspondence from the state regulatory entity, and Defendants' written response on Simple Health or Health Benefits Center letterhead. Many complaint folders included a subject title in their names, such as "(ACA)," "(Misrep.)," and "(70%)," among others. I have attached a sample of 21 complaints. True and correct copies of these complaints are attached hereto as **Al-Najjar Attachment A.**

ONGOING CONSUMER CHARGES

5. FTC staff requested information from the Receiver about consumers currently being charged by Defendants' third party administrator, Health Insurance Innovations, for products previously purchased from Defendants. On or around January 31, 2019, FTC staff received an email from the Receiver forwarding an email from HII's counsel with a Microsoft Excel spreadsheet titled "Simple Health – December Collections and Allocations" attached. According to the spreadsheet, 62,108 unique charges occurred during the month of December 2018, resulting in approximately $5.5 million in revenue. One column of this spreadsheet is titled "Sales commissions due to Simple Health." The amount listed at the bottom of this column is $73,314.77.

6. On or around March 14, 2019, the Receiver sent FTC staff a Microsoft Excel spreadsheet titled "Simple Health – January Collections and Allocations." According to this spreadsheet, 54,851 unique charges occurred during the month of January 2019, resulting in approximately $4.8 million in revenue. One column of this spreadsheet is titled "Sales

commissions due to Simple Health." The amount listed at the bottom of this column is $2,385,201.40.

7. On or around March 14, 2019, the Receiver sent FTC staff a Microsoft Excel spreadsheet titled "Simple Health – February Collections and Allocations." According to this spreadsheet, 48,839 unique charges occurred during the month of February 2019, resulting in approximately $4.3 million in revenue. One column of this spreadsheet is titled "Sales commissions due to Simple Health." The amount listed at the bottom of this column is $2,150,936.48.

I declare under penalty of perjury that the foregoing statement is true and correct.

Executed on March 18, 2019.

Nathaniel Al-Najjar

Al-Najjar Attachment A

Missouri Department of Insurance
P O Box 690
Jefferson City
MO 65101-0690
1-800-726-7390
www.insurance.mo.gov

Other Reason Desc:

*Details of the Complaint:
My brother, R[redacted] called to get health insurance during the open enrollment period. He called Blue Cross to sign up for coverage. He was then transferred to this company. So he was under the impression he was still talking to a branch of Blue Cross. This company lied and led him to believe he was signing up for a health insurance policy. When he received the paperwork and showed it to me I realized it was a supplement coverage and not health coverage. Unfortunately it is now past the open enrollment and he can not get health coverage thru Obama Care now. Is it possible since he was lied to by this company that he can do a repeal to still enroll in a health coverage? I am trying to help my brother because he has limited education and does not understand technical information very well and he was lied to and led into believing he was signing up for Health Care coverage. I think this was a very unfair of this company to take advantage of someone and leave him with no health insurance and without the possibility of now being able to correct the problem without paying for an expensive monthly charge he can't afford. He is single never married and only makes around $36,000 a year. So he can't afford to pay for a $500 a month payment for health coverage.

*What do you consider to be a fair resolution?

He can cancel this coverage if he cancels by January 15, 2018 and not continue being charged for it but I feel he should be granted an appeal to still sign up for Obama Care since he was lied to from the beginning from this company that he was getting health insurance coverage and in reality it was not. It is not far past the cutoff for open enrollment and would greatly appreciate any help he can receive with this problem

Will you be mailing or faxing additional supporting information: Yes

If mailing supporting documents, please include a copy of this form and mail to:
Missouri Department of Insurance
Attn: Consumer Affairs
P O Box 690
Jefferson City, MO 65101-0690
or FAX supporting documents along with a copy of this form to: (573) 526-4898

I declare the information provided is true and accurate. I hereby authorize the insurer or persons or entities complained against to release all claim and policy information and documents, including medical records, to the Missouri Department of Insurance on request.
Authorized: Yes

Simple Health

Health Benefits One

Response

January 23, 2018

State of Missouri
Department of Insurance

COMPLAINT RESPONSE

Re: L[redacted] H[redacted]
Tracking ID: 307887

To Whom It May Concern:

Please allow this letter to serve as a formal response to an inquiry from the State of Missouri Department of Insurance regarding a membership with Health Care USA+; a Protector 360 Limited Medical Indemnity plan underwritten by Humana Insurance Company for L[redacted] H[redacted] on behalf of [redacted] A[redacted] (who will be referred to as the member throughout this response).

December 15, 2017, member did a needs and cost analysis to find a suitable product. During the pre-qualifying stage, the member was asked to state any pre-existing conditions. Once paired with a product, the member was then transferred to the verification department for an EchoSign Packet with the details of the product and/or products they chose to purchase. This is done for the protection of the member to ensure their understanding of purchase.

Simple Health

Member was advised of the overview of the Benefits, Association and Humana Network, Limitations & Exclusions and Security & Privacy which are available immediately for their viewing by going www.hiiquote.com. HBO further advised the member to review the policy and certificate for a list of any exclusions, limitations and acknowledgements specific to their state. The member was explained several times the membership was not a major medical, but rather a limited medical benefit plan.

Per the member's complaint form, the member stated he called Blue Cross and was transferred to Simple Health for health coverage. Please be advised that at no time was the member advised this was Blue Cross Blue Shield. The member was advised this policy was a limited medical indemnity policy which provided a cash benefit, which he could receive in-network repricing for any applicable procedures within the network. The member acknowledged and agreed to the terms and conditions of the policy during the enrollment process.

Should you have any additional questions regarding this, please feel free to contact our Compliance Department at 1-800-492-1834.

Sincerely,

Jeffrey Auguste

8/21/2017

[redacted] and [redacted]

[redacted]

Burlington, CO [redacted]

[redacted]

Thank you for the understanding and helpful information and thank you for the opportunity to tell our story.

1st Insurance Company of concern is" Companion Life" (Principal Advantage Limited Benefit Health Insurance) Billing and non-claims 1-877-376-5831, claims 1-800-952-7420

2nd Our policy number is- [redacted] Group number is [redacted]

3rd Applicant is [redacted] insured spouse [redacted]

4th effective date 9/10/2015

Explanation:

In the Fall of 2015 We were forced to renew our insurance policy and had to pick up insurance from the Colorado Exchange. We were really not very prepared to do this as everything was very new to us with the new insurance policies.

We did a search online for the Colorado Health Exchange and was directed to a web site that looked very official and was told that we had to fill out our contact information in order to start the process, so we filled out our information and hit enter. The phone rang not three seconds from the time we entered our information. The person from HII Quote on the other end explained how well this policy would work for us as we are over the road truckers and needed a multi-state policy. I questioned how does the policy work and what was the deductible. HII Quotes explanation was that they negotiate the charges and they pay on the lesser amount. We would owe the difference from the negotiated amount and the amount charged if the billing party did not except the negotiated amount.

We never questioned the policy as we never used it until Feb 2016 when [redacted] was admitted into the Hospital in Pierre SD for acute chest pain by ambulance. She was then flown to Rapid City SD to meet with awaiting Heart Specialist group where the performed a cardio vascular and found three spots in the veins of her heart where the veins were twisted like a candy wrapper. The team inserted two stents that opened the three twisted areas. Her condition is not heart disease but a heredity condition unable to be found using usual testing measures.

First Ambulance was Jones County EMS. They billed $1560.00 Insurance paid $0

St Mary's Hospital Pierre SD billed $1,2910.71 Insurance paid $50.00

Dr. Meyer Billed $909.04 Insurance paid $50.00

Dr. Meyer Billed $131.60 Insurance paid $0

Ambulance to airport billed $775.54 Insurance paid $0

Air flight to Rapid City SD billed $$30,435.00 Insurance paid $0

Ambulance from airport to Rapid City Hospital billed $1,244.00 Insurance paid $0

Rapid City Hospital Billed $54,915.77 Insurance paid $0

Regional Heart Doctors billed &7,172.00 Insurance Paid $0

Ongoing care Dr. Skinner billed $20.19 Insurance paid $20.19

Ongoing care Dr. Skinner billed $307.00 Insurance paid $79.81

In total the Insurance company paid $200.00

Total Billed to this insurance company $110,380.85

We are forced to do self-pay on the remaining charges and have been turned into collections for most of the charges, others we have taken out loans for and have made payment arrangements for the rest.

The hospital in Rapid City, SD has been helping us file claims and gather information and has been working on our behalf to communicate with the insurance Company. Our rep there has all of the phone transcripts and other information that may be pertinent. I have all of the Bills and the payment information from the Insurance company available.

In all we have been hammered from collections, killing our credit ratio. We have maxed out our borrowing capacity and are making payments that are stretching our budget. In all We feel that we were scammed in buying the policy in the first place, and have been mistreated while having the policy. The company is intentionally stalling and will never pay any of the remaining charges leaving the creditors holding the bag as we struggle to pay them. We would like to bring them to the table and explain themselves.

We also found out from our accountant that we would be fined for tax year 2015 and part for 2016 for not having health insurance that did not meet the federal compliance standards. We also found out that the company did not have to alert of the fact that the policy they offered was not compliant because we are self-employed.

[redacted]and B[redacted] B[redacted]

[redacted]

Health Benefits One

Response

September 14, 2017

State of Colorado
Division of Insurance

COMPLAINT RESPONSE

Re: B[redacted] B[redacted]

To Whom It May Concern:

Please allow this letter to serve as a formal response to an inquiry from the State of Colorado Division of Insurance, regarding a membership with MSGA; a Principal Advantage limited Medical Indemnity plan underwritten by Companion Life Insurance Company on behalf of B[redacted] B[redacted] (who will be referred to as the member throughout this response).

September 05, 2015, member did a needs and cost analysis to find a suitable product. During the pre-qualifying stage, the member was asked to state any pre-existing conditions. Once paired with a product, the member was then transferred to the verification department for a voice verification with the details of the product and/or products they chose to purchase. This is done for the protection of the member to ensure their understanding of purchase.

Member was advised of the overview of the Benefits, Association and Multiplan Network, Limitations & Exclusions and Security & Privacy which are available immediately for their viewing by going www.hiiquote.com. HBO further advised the member to review the policy and certificate for a list of any exclusions, limitations and acknowledgements specific to their state.

Per the member's complaint form, the member's husband stated his wife Barbara Bates was admitted into the hospital and nothing was covered. During the sales and enrollment process the member was advised this policy was a limited medical indemnity policy that provided a cash benefit. As part of the MSGA association, the member could receive in-network re-pricing for any applicable procedures within the network.The pre-existing waiting period was explained during the sale and verification process.

Please be advised Health Benefits One, LLC does not handle claims.

Should you have any additional questions regarding this, please feel free to contact our Compliance Department at 1-800-492-1834.

Please be advised Alexis Danielle Akins is no longer with Health Benefits One, LLC. Please accept this on my behalf as the Chief Compliance Officer.

Sincerely,

C.Girouard

C.Girouard

▶ My complaint concerns

My claim was denied ☐ My rates are too high Customer service My doctor is out of network

My insurance company owes me a refund ☐ My claim was underpaid Delayed claim payment

☐ My agent stole my premium Improper claim/policy notice Agent misrepresented/failed to explain policy terms

[redacted]

Email Confirm email

TDI may release my email address in response to a public information request? Yes No

▶ My complaint is:

I wanted to purchase a health insurance policy through the exchange prior to the Open Enrollment Deadline of December 15th to avoid the tax penalty. I called the company on December 13th and explained to them I wanted to enroll in coverage to meet the deadline. The representative sold me a plan and led me to believe it meet the guidelines through the affordable care act. I was clear with him that I was trying to enroll before the cut off date. The representative told me the coverage would start that same day or the next day. Once I had coverage in place I went to see a doctor to get a check up on the 27th. The day after my check up the doctor called me and told me I had to go to the hospital right away. On the 28th, I went to the hospital and they started doing exams to find out what was going on and I was told my kidneys were damaged from high blood pressure and on subsequent follow ups it was determined I would need dialysis. I started doing work ups and appointments to prepare for treatment. On January 9th, I started investigating my coverage for dialysis and found out that my plan did not provide coverage for dialysis. I also found out that my plan did not meet he requirements for the Affordable Care Act. Not only do I not have coverage, but I will also face a tax penalty after specifically being proactive and telling the agent who sold me the policy that I wanted health coverage to avoid being cut off from the Healthcare Marketplace deadline of December 15th. The agent sold me a plan that could be bought any time of the year and I was not aware of that. The representative mislead me to believe the plan I was purchasing would be compliant with current healthcare and tax laws.

What do you consider a fair resolution to your problem?

I would like for the agent or company that sold me this plan to be held responsible for the cost of my dialysis, possible transplant, and other medical services that are not covered by this plan that would have been covered by a plan that met the Affordable Care Act requirements until I become eligible for coverage in the next Open Enrollment period. If the agent has an Errors and Ommissions policy I would like them to cover my medical services for dialysis, transplant, and other treatment or medical services that would have been covered under a plan that met ACA standards.

If you need more space, please attach additional pages.

Note: A copy of this complaint will be sent to the insurance companies or agents involved.

Have you submitted this complaint to TDI previously? Yes No Complaint ID #_____

Simple Health

Health Benefits One

Response

February 13, 2018

State of Texas
Department of Insurance

COMPLAINT RESPONSE

Re: A[redacted] B[redacted]
Problem Report ID: 201471

To Whom It May Concern:

Please allow this letter to serve as a formal response to an inquiry from the State of Texas Department of Insurance regarding a membership with National Congress of Employers Association; a Health Choice + Limited Medical Indemnity plan underwritten by American Financial Security Life Insurance Company for A[redacted] B[redacted] (who will be referred to as the member throughout this response).

December 13, 2017, member did a needs and cost analysis to find a suitable product. During the pre-qualifying stage, the member was asked to state any pre-existing conditions. Once paired with a product, the member was then transferred to the verification department for a voice verification with the details of the product and/or products they chose to purchase. This is done for the protection of the member to ensure their understanding of purchase.

Member was advised of the overview of the Benefits, Association and, American Financial Limitations & Exclusions and Security & Privacy which are available immediately for their viewing by going www.hiiquote.com. HBO further advised the member to review the policy and certificate for a list of any exclusions, limitations and acknowledgements specific to their state. The member was explained several times the membership was not a major medical, but rather a limited medical benefit plan.

Per the member's complaint form, the member stated he needed to purchase a health insurance policy covered under ACA. During the enrollment process it was discussed with the member this policy was a limited medical benefit plan which did not meet the Affordable Healthcare Act guidelines.

The member further stated he was diagnosed with Kidney disease and needed to have Dialysis treatments, but the policy did not cover it. The member was advised this policy was a limited medical indemnity policy which provided a cash benefit which he could receive in-network repricing for any doctor within the network. The member also acknowledged and agreed to the terms and conditions of the policy during the enrollment process.

Should you have any additional questions regarding this, please feel free to contact our Compliance Department at 1-800-492-1834.

Please be advised Javier Perez has taken 30 days of leave due to family matters. Please accept this on behalf of myself as the Chief Compliance Officer.

Sincerely,

C.Girouard

C.Girouard

- State:
- Zip:
- Phone:

Department of Insurance

- Have you previously written to the Department of Insurance about this matter? **No**
- If yes, please give file number:
- Date written:

Government Agencies

- Have you reported this to other governmental agencies? **No**
- If yes, please give name of agency and file number:

Attorney

- Do you have an attorney representing you? **No**
- Is there court action pending? **No**

Problem

- Briefly describe your problem: **Almost 2 months after i lost insurance through my former company, I had signed up for Medicaid for the our Kids but we were ineligible. My company was offering insurance but it was approximately 800.00 a month. Due to not being able to afford it, i opted out and i got online and a representative from Health Insurance Innovations representing First health called. She sold me on a Legion limited health plan that included medical, dental, and vision with a pharmacy discount card. She stated many times that this Group insurance was better than traditional insurance because of not having deductibles, which reduced out of pocket expenses. There was a significant reduction in bills when going to the ER or doctors due to the contracted rates, and then additionally this insurance takes off additional monies because it is a large group plan so they can do this. And then a bill is submitted to me. Being as skeptical as i was, and wanting the best insurance i could get. I asked many many times if we would be covered if needing to go to our doctors, or an ER visit with having 3 kids. I even gave scenarios. She repeatedly stated yes, and even went through finding our doctors to see if they were in network; which they all were. With not having a lot of money, this sounded good, with not having to pay so much for insurance like we were looking at having too. Shortly after the insurance started, i started calling to find out what my policy coverage was and they stated that i should go to my signature page, but when there i could not find anything on it, other than the coverage on dental and vision. i quickly cancelled my dental and vision and pharmacy plans due to getting better care from the company i work at. After my wife went to the ER for a hypertensive problem and my daughter had to have an pain injection in her back. I was told that our insurance denied the injection all together because it was not covered. I was told that even the ER was not covered under our plan. Axis stated that we had no benefits for these types of visits under our plan. I called Health Insurance Innovation on 13 separate occasions (According to HII representative) trying to get this figured out and on 5 or 6 occasions called requesting better insurance and a quote. No one ever returned my calls on each of these times. When talking with them i got a range of responses that their systems have been down, to the systems to talk to one another. Even had a supervisor tell me that this was not right, he could see in the records that i have been having major problems, requesting for better insurance and that he was going to have someone call me within 2-3 business day. On the last time i called, i was told that they should have told me long before this that i was not eligible to have any insurance like what i was requesting (major medical) and would have to wait until November. In may i cancelled my insurance with this company due to not having any insurance but just a discount plan. I have received bills totaling over 10,000.00 dollars for my wife's ER visit, 10,000.00 dollars in bills for my daughters injection in her back, which i was luckily able to get medicaid to cover as secondary, and have had a bill over 600 dollars for myself to go see the ENT. Today i got an EOB from Axis on my oldest daughter that they covered 50.00 on a regular doctor bill that was 300.00 and a contracted rate that gave 30.00 discount.**

Resolution

- What do you consider to be a solution to your problem? **I would like th[redacted]lls payed that have been encoured as a result of Health Insurance Innovations misrepresenting a discount plan in place of insurance. When i spoke with them i was still under the 60 days from losing insurnace from my prior job, and would have been able to get a major medical insurance which would not have had the outcome of high bills.**

Disclosure

- Date: **7/2/2017**
- Signature: **S[redacted]C[redacted]**

E-Mail to and from me, in connection with the transaction of public business, is subject to the Wyoming Public Records Act and may be disclosed to third parties.

Health Benefits One

Response

July 11, 2017

State of Wyoming
Department of Insurance

COMPLAINT RESPONSE

Re: S[redacted] C[redacted]
WID File Number: 17-9547LD

To Whom It May Concern:

Please allow this letter to serve as a formal response to an inquiry from the State of Wyoming Department of Insurance regarding a membership with ACUSA: a Legion Limited Indemnity plan underwritten by AXIS Insurance Company for S[redacted] C[redacted] (who will be referred to as the member throughout this response).

March 08, 2017, member did a needs and cost analysis to find a suitable product. During the pre-qualifying stage, the member was asked to state any pre-existing conditions. Once paired with a product, the member was then transferred to the verification department for an Echosign Packet with the details of the product and/or products they chose to purchase. This is done for the protection of the member to ensure their understanding of purchase.

Member was advised of the overview of the Benefits, Association and First Health Network, Limitations & Exclusions and Security & Privacy which are available immediately for their viewing by going www.hiiquote.com. HBO further advised the member to review the policy and certificate for a list of any exclusions, limitations and acknowledgements specific to their state.

Per the members complaint form, the member stated his wife and daughter went to the emergency room and were told the policy did not cover the procedures and he also received unpaid bills for the visits. Please be advised that during the enrollment process the member was informed the policy he was enrolling into was a limited benefits medical policy. The member also acknowledged and agreed to the terms and conditions of the policy during the enrollment and verification process.

Please be advised that Health Benefits One, LLC does not handle claims.

Please be advised Christopher Pierre Louis is no longer with Health Benefits One, LLC. Please accept this on my behalf as the Chief Compliance Officer.

Should you have any additional questions regarding this, please feel free to contact our Compliance Department at 1-800-492-1834.

Sincerely,

C. Girouard

C. Girouard

2017 06 05 202810

Gabriel
WEB-TPA
PO Box 99906
Grapevine, TX 76099

May 31, 2017

RE: M[redacted]
EDI Payor ID# [redacted]

Gabriel,

I feel frustrated, lied to, angry, etc.,.

My granddaughter, M[redacted] moved back to Oklahoma from Oregon in August, 2016. M[redacted] has been a Type 1 diabetic since she was 9 years old. Finding good Health Insurance is very important. I went online, filled out questionnaires and received several phone calls from insurance companies. I was careful to make sure diabetic health care with possible multiple hospital visits was necessary in M[redacted] case because she is considered a "brittle" diabetic. M[redacted] gets sick to her stomach, vomits and this throws her blood gases out of balance and she goes into DKA (diabetic Ketoacidosis). Hospital care is required to correct this condition.

Your salesman assured me this policy was what M[redacted] needed. I have recently received past due notices from Integris Grove Hospital and then Collection Agency letters. In talking with Integris Grove Hospital I was told these invoices were declined due to a preexisting condition so I called your company and was told that no, they were declined because billing codes were not included on the invoices. I called Integris Grove and requested copies of all invoices with billing codes. Last week when I called to get an "attn to" person to mail these invoices to and spoke to you, Gabriel, and was told that in fact this is not a health insurance policy and I'm not sure

what it's supposed to do. 2017 06 05 202812

I have called to try to get health insurance for M[redacted] and have been informed that because your policy is not a health insurance policy M[redacted] has not been insured since August 2016 and because health insurance has an enrollment perio[redacted] cannot get health insurance until November, 2017. Thank you very much.

What do you suggest we do now? M[redacted] has no health insurance, cannot get health insurance and has over $53,000. in medical bills that neither she or I can possibly pay. Again, thank you very much.

I would cancel M[redacted] policy with you today and request payment in full of all premiums paid to date in the amount of $917.20 and am contacting the Oklahoma Insurance commission to see if anything can be done about this situation.

M[redacted]

Thank you,
Carlene McEwin
Claims Manager
P: 469-417-1723
F: 469-417-1954
carlene.mcewin@webtpa.com

WebTPA
An AmWINS Group Company

WebTPA, An AmWINS Group Company
8500 Freeport Parkway South, Suite 400
Irving, TX 75063

07/06/17 Timothy.McCarthy@amwins.com

Health Benefits One

Response

July 07, 2017

COMPLAINT RESPONSE

Re: M[redacted] F[redacted]

To Whom It May Concern:

Please allow this letter to serve as a formal response to the complainant's concerns, regarding a membership with MSGA; a Principal Advantage limited Medical Indemnity plan underwritten by Companion Life Insurance Company for M[redacted] F[redacted] on behalf of M[redacted] F[redacted] (who will be referred to as the member throughout this response).

August 19, 2016, member did a needs and cost analysis to find a suitable product. During the pre-qualifying stage, the member was asked to state any pre-existing conditions. Once paired with a product, the member was then transferred to the verification department for an EchoSign Packet with the details of the product and/or products they chose to purchase. This is done for the protection of the member to ensure their understanding of purchase.

Member was advised of the overview of the Benefits, Association and Multiplan Network, Limitations & Exclusions and Security & Privacy which are available immediately for their viewing by going www.hiiquote.com. HBO further advised the member to review the policy and certificate for a list of any exclusions, limitations and acknowledgements specific to their state.

Per the member's complaint form, the member's grandmother stated she was told the policy would cover the member's diabetes, but has been receiving past due notices for unpaid claims for hospitalization. During the sales and enrollment process the member was advised that this policy was a limited medical indemnity policy that provided a cash benefit. As part of the MSGA association, the member could receive in-network re-pricing for any applicable procedures within the network.The pre-existing waiting period was explained during the sale and verification process.

Please be advised Health Benefits One, LLC does not handle claims.

Should you have any additional questions regarding this, please feel free to contact our Compliance Department at 1-800-492-1834.

Please be advised Adam Bercowicz is no longer with Health Benefits One, LLC. Please accept this on my behalf as the Chief Compliance Officer.

Sincerely,

C.Girouard

C.Girouard

Problem Report Information Inquiry

Problem Report ID: 42517 **Problem Report Type:** Complaint **Responsible Section:** Consumer Services

Status: Open **Opened Date:** 07-06-2017 **Closed Date:** **Closure Reason:**

PROBLEM REPORT DETAILS

TYPE OF PROBLEM	OTHER PROBLEM TYPE DESCRIPTION
Provider Issues	

DESCRIPTION

CONSUMER DETAIL OF COMPLAINT

I've contacted over 25 different OB/GYN doctors in Las Vegas and went to Southern Hills Hospital for treatment and was told this is not health insurance! I am pregnant and need to get care for my baby and I have had to pay over $1500 out of pocket and that amount is still rising because I am currently uninsured. I had to cancel the policy due to the fact that not one doctors office nor hospital accepted this "Unified Health One" as valid health insurance. The supposed insurance is underwritten by: Unified Life Insurance Company. I believe I was sold health insurance under false pretenses or sales misrepresentation. I am currently trying to buy health insurance and I need to prove loss of insurance but Unified Health One (also called Health Insurance Innovations) will only send me a written statement claiming I cancelled the policy at my own will. Which I wouldn't have had to cancel if they provided legitimate health insurance!
Also, I want to know why the Nevada Division of Insurance doesn't recognize Unified Health One at all, but it does recognize Unified Life insurance company as a health and life insurance company. It is very confusing. Also Health Insurance Innovations is not a health care provider but a third party administration health plan intermediary LLC. This is all so confusing and concerning. I have also done further research and other consumers have declared this to be a fraudulent company that prays upon people like myself. This company contacted me. They sold me insurance that does not work. Like they have done to so many others. They also refunded my money well passed the 30 days that allows them when I confronted them with the fact that they are bogus health insurance. If they are truly valid why would they do that?
I just want to know what they are and if they are valid. Also, when I asked for them to send me a list of providers, they kept resending me my member cards. When I tried to search their portal to find doctors it was impossible.

CONSUMER DESIRED RESOLUTION

A fair resolution would be that they are responsible for every single penny I have had to come out of pocket and a vast portion of my hospital bills! If they were true health coverage, my hospital bills would have come to maybe $900, and my doctors visits I would have only had to pay the $75 copay for the specialists being that I am a high risk patient. This company (Unified Life Insurance Company, Unified Health One, or Health Insurance Innovations) has caused me a significant amount of emotional stress and a significant amount of debt that it at times consumes me.
I also think that they should be fined by the state in some way for preying upon people in such a way. I have Never dealt with such a shady insurance company such as this.

CONSUMER IS COMPLAINING AGAINST	CONSUMER IS REPRESENTED BY AN ATTORNEY?	HOW DID THE CONSUMER KNOW ABOUT US?
My Insurance Company	No	Consumer Portal

HAS THE CONSUMER PREVIOUSLY REPORTED THIS PROBLEM TO OUR OFFICE OR ANY OTHER AGENCY?	PURCHASED INSURANCE ON THE HEALTH CARE EXCHANGE?
Yes	Yes

RESPONDENT INFORMATION

NAME	ADDRESS	EIN/NPN
UNIFIED LIFE INSURANCE COMPANY	PO BOX 25326 OVERLAND PARKKS 66225-5326	43-1917728

EMPLOYMENT TYPE	NAIC ID	REPRESENTATIVE	COMPLAINT CONFIRMED
	11121		

SOURCE	COMPLAINT TYPE	INCIDENT DATE	RECEIVED DATE	PRIORITY	LOCATION	LOCATION DATE
Consumer	General	05-24-2016			Las Vegas	

FINDING TYPE	INCIDENT GROUP	SUBJECT	SUBJECT ADDITIONAL DETAILS	STATE ID	SYSTEM SOURCE
				SH	

INSURER	AGENT/AGENCY	TYPE OF INSURANCE	SELF-FUNDED HEALTH PLAN	COVERAGE TYPE	COVERAGE LEVEL	COVERAGE SUBLEVELS
Unified life insurance company	Health insurance innovations	Accident and Health	No	Accident and Health	Individual	Health Only

NAME OF INSURED	POLICY NUMBER	POLICY PERIOD BEGIN DATE	POLICY PERIOD END DATE	POLICY ISSUED STATE	INSURANCE CARD ID	CLAIM NUMBER
F[redacted] V[redacted] [redacted]	[redacted]			Nevada	200442680	

TYPE OF POLICY	LOCATION OF LOSS	IS THE INSURED MEDICARE	MEDICARE SUPP. PLAN	OTHER PARTY'S POLICY OR CLAIM NUMBER
		No		

Health Benefits One

Response

July 13, 2017

State of Nevada
Division of Insurance

COMPLAINT RESPONSE

Re: V[redacted] F[redacted]
Problem Report ID: 42517

To Whom It May Concern:

Please allow this letter to serve as a formal response to an inquiry from the State of Nevada Division of Insurance regarding a membership with NCE; a Unified Health One Limited Medical Indemnity plan underwritten by Unified Life Insurance Company for V[redacted] F[redacted] (who will be referred to as the member throughout this response).

March 29, 2017, member did a needs and cost analysis to find a suitable product. During the pre-qualifying stage, the member was asked to state any pre-existing conditions. Once paired with a product, the member was then transferred to the verification department for an EchoSign Packet with the details of the product and/or products they chose to purchase. This is done for the protection of the member to ensure their understanding of purchase.

Member was advised of the overview of the Benefits, Association and Multiplan Network, Limitations & Exclusions and Security & Privacy which are available immediately for their viewing by going www.hiiquote.com. HBO further advised the member to review the policy and certificate for a list of any exclusions, limitations and acknowledgements specific to their state.

Per the member's complaint form, the member stated she has not been able to receive any benefits for her maternity visits. Please be advised the member was told this policy does not have maternity benefits. It must further be stated the member never stated she was looking for maternity coverage.

Should you have any additional questions regarding this, please feel free to contact our Compliance Department at 1-800-492-1834.

Please be advised Sheri Hammerman is not available at this time. Please accept this on behalf of myself as the Chief Compliance Officer.

Sincerely,

C.Girouard

C.Girouard

Details of Complaint

Description:

Companion Life refused to pay for any portion of my medical bills that involved my appendix having to be removed. I believe they sold me a fraudulent health insurance policy. I'm supposed to come up with about $26,000 to cover all the related bills. That's more money than I make in a year. When I contacted the insurance company they would assure me that some of the cost would be covered. They would tell me that the hospitals weren't billing them correctly. I found myself between the insurance company and the hospitals and stuck with all the bills. There's no way I can satisfy these billing departments. I don't make enough money to enter any of the hospitals proposed payment plans and some bills have now gone to collection agencies.

Resolution:

I think the Companion Life Insurance Company should be exposed for selling fraudulent insurance policies.

Simple Health

Health Benefits One

Response

August 14, 2018

State of Wisconsin
Office of the Commissioner of Insurance

COMPLAINT RESPONSE

Re: B[redacted] F[redacted]
File Number: 346394

To Whom It May Concern:

Please allow this letter to serve as a formal response to an inquiry from the State of Wisconsin Office of the Commissioner of Insurance regarding a membership with MSGA; a Principle Advantage Limited Medical Indemnity plan underwritten by Companion Life Insurance Company for B[redacted] F[redacted](who will be referred to as the member throughout this response).

July 07, 2016, member did a needs and cost analysis to find a suitable product. During the pre-qualifying stage, the member was asked to state any pre-existing conditions. Once paired with a product, the member was then transferred to the verification department for an EchoSign Packet with the details of the product and/or products they chose to purchase. This is done for the protection of the member to ensure their understanding of purchase.

Member was advised of the overview of the Benefits, Association and Multiplan Network, Limitations & Exclusions and Security & Privacy which are available immediately for their viewing by going www.hiiquote.com. HBO further advised the member to review the policy and certificate for a list of any exclusions, limitations and acknowledgements specific to their state.

Per the member's complaint form, the member stated he had his appendix removed and his claims were not paid. During the enrollment process, the member was advised that the policy he was enrolling into was a limited medical indemnity policy that provided a cash benefit. The member was also informed that if the hospital was within the Multiplan Network he could receive an in-network contracted rate for any approved procedures. The member also acknowledged and agreed to the terms and conditions of the policy, including but not limited to, Waiting period, Coverage, and Pre-Existing conditions provision.

Please be advised Heath Benefits One, LLC does not handle claims.

Should you have any additional questions regarding this, please feel free to contact our Compliance Department at 1-800-492-1834.

Please be advised Edward Jacobs is no longer with Health Benefits One, LLC. Please accept this on behalf of myself as the Chief Compliance Officer.

Sincerely,

C. Girouard

C. Girouard

13. Please describe your problem in detail. Attach additional pages, if necessary. Please include **copies** of important papers, letters, or other information, if they relate to your problem.

PLEASE SEND COPIES ONLY—NO ORIGINALS AND NO PHOTOS.

I was sold a supposed Obama Care health ins coverage. I was lied to about the coverage. I was told If I waited to see a Doctor for a couple of premiums of monthly payments my cost would be nothing for Dr visit. (Plan covered maximum of $80.00 per visit) I was also led to believe I needed Life Ins to go with health Ins. I Bought it was a package deal for getting Obama Care. So I have a heart procedure that cost about $92,000 + Ins covers $2000.00. How can you be required to have health ins or get penalized + obama care covers basicly nothing. I had asked for Ins Policy to be mailed to Me + did not receive anything, so I call a month Later + still took forever to get. When I found out Ins covered almost nothing I was told my agent was no Longer There. Then found out it wasn't mandatory to have Life Ins with Health. When Ins covered nothing I dropped it all.

14. Please indicate how you think your problem should be resolved.

I do not know if agents sales calls are Taped or not but I was totally misled. I believe agent or Ins Co He represents should be held accountable

15. Have you previously reported this problem to us or any other governmental agency?

☐ Yes ☒ No If yes, state which agency and what action was taken?

Consent to Release Information

The information I have given above is true and accurate to the best of my knowledge and belief. This information may be forwarded to the insurance company and/or agent involved. Any medical information which I have provided, may be shared with the insurance company, if necessary for the investigation of this matter. I understand that under Wisconsin's Open Records Law all information which is in my file, including personal and health information, may become a public record once my file is closed. Only actual medical records which are obtained from a health care provider are confidential under s. 146.82, Wis. Stat.

E[redacted] J[redacted]
Signa[redacted]

5-25-17
Date

Health Benefits One

Response

June 13, 2017

State of Wisconsin
Office of the Commissioner of Insurance

COMPLAINT RESPONSE

Re: E[redacted] F[redacted]
File Number:336193

To Whom It May Concern:

Please allow this letter to serve as a formal response to an inquiry from the State of Wisconsin Office of the Commissioner of Insurance regarding a membership with MSGA: a Principle Advantage Limited Medical Indemnity plan underwritten by Companion Life Insurance Company for E[redacted] F[redacted] (who will be referred to as the member throughout this response).

August 5, 2014, member did a needs and cost analysis to find a suitable product. During the pre-qualifying stage, the member was asked to state any pre-existing conditions. Once paired with a product, the member was then transferred to the verification department for a voice verification with the details of the product and/or products they chose to purchase. This is done for the protection of the member to ensure their understanding of purchase.

Member was advised of the overview of the Benefits, Association and Multiplan Network, Limitations & Exclusions and Security & Privacy which are available immediately for their viewing by going www.hiiquote.com. HBO further advised the member to review the policy and certificate for a list of any exclusions, limitations and acknowledgements specific to their state.

Per the member's complaint form, the member stated he was advised he would pay nothing for doctor visits after paying a few months of premiums, the member further states he was led to believe this was an Obamacare plan. During the sales and enrollment process the member was advised that this policy was a limited medical indemnity policy that provided a cash benefit. As part of the MSGA association, the member could receive in-network re-pricing for any applicable procedures within the network. The member was fully ware this plan did not qualify as an Obamacare plan because it was not a major medical.

Please be advised the member went through a separate verification for the accidental death and dismemberment policy which states the following:

"*You do understand that all the benefits, underwriting and billing for your accidental death benefit with Fidelity Life Association are completely separate from and have no association with any other products, services, packages or bundles, you may have discussed or may be purchasing today. All cancellations must be done so separately from any other product. Furthermore, you are NOT required to purchase the accidental death benefit policy as part of any other product, service package or bundle. If you understand this and wish to continue, please verify by saying yes.*"

Should you have any additional questions regarding this, please feel free to contact our Compliance Department at 1-800-492-1834.

Please be advised Alane Kravatz is no longer with Health Benefits One, LLC. Please accept this on behalf of myself as the Chief Compliance Officer.

Sincerely,

C. Girouard

C. Girouard

9. Briefly describe your problem and state how you feel it should be resolved. If you feel that copies of your policy, correspondence or other supporting documentation will assist us in understanding or evaluating the issues, please send copies to us. If more space is needed to describe your problem, please attach additional sheets.

I recieved word from the financial office of three rivers Para mgt Stating My Medical Insurance Company has not Paid any of the medical Bills. and they were going to stop seeing me Due to Non-Payment the Bill is $6,883.87. I Called the insurance Company to ask why they said I was on Plan 1 and that Plan only Pays 50 Dollars for 3 visits a year the Plan I was sold was for Plan 3 which would Pay for Pretty much everythi

PLEASE READ, SIGN AND DATE THE STATEMENT BELOW:

I CERTIFY THAT THE INFORMATION THAT I HAVE GIVEN ABOVE IS TRUE AND ACCURATE TO THE BEST OF MY KNOWLEDGE AND BELIEF. I UNDERSTAND THAT A COPY OF THIS FORM AND ATTACHMENTS MAY BE FORWARDED TO THE INSURANCE COM[redacted], AGENT OR BROKER INVOLVED.

(Sign[redacted]) (Date) 8-30-18

OPTIONAL- (IF YOUR COMPLAINT INVOLVES A MEDICAL ISSUE OR CREDIT INFORMATION) Please circle either Medical Issue, Credit Information or Both.

I AUTHORIZE AXIS (Name of Insurance Company)TO RELEASE TO THE PENNSYLVANIA INSURANCE DEPARTMENT ANY **MEDICAL/CREDIT INFORMATION** WH[redacted] MAY BE PERTINENT TO THE RESOLUTION OF MY COMPLAINT.

(Signature) (Date) 8-30-18

Mail or Fax Complaint Form to:

Pennsylvania Insurance Department
Bureau of Consumer Services
Room 1209, Strawberry Square
Harrisburg, PA 17120
Fax: (717) 787-8585

Toll Free: 1-877-881-6388

Please feel free to submit your question or complaint on-line at:

Website: www.insurance.pa.gov

PS-4 (REV. 07/11)

To whom it may concern,

I received a call from Healthcare Innovations at the end January 2017. The guy I spoke to was named Mark. He talked to me about how important health insurance was and that he had the plan that would fit my needs. We went on to talk about 3 different medical insurance plans. The first one was pretty cheap and didn't really cover anything, so we talked about plan two. It covered pretty much what I needed, but my doctors were not in the service area so we went on to plan three. Plan three covered all of my doctors, and had a $50 co pay for ER visits and a $10 co pay for office visits and prescription coverage. I was pretty excited about that. Meds can be pretty expensive. Vision and dental could be added per my request.

My coverage was to start at midnight on February 2, 2018. Startup was $438.00 and my payments would be $258.00 and some change the last day of every month. I received a call this August 2018 from Three Rivers Pain Management; one of my doctors saying that I owed a bill of $5,888.00 and they couldn't see me any more until I paid something on the bill. I asked how, said I have insurance, and was told that I exhausted the amount that they pay for a year. I called the insurance company, which I found out doesn't just have one name, it has many, and it's underwritten by Axis. I talked to a lady named Cathy and she told me she had no clue what they were talking about, but that she would call me back. I still haven't heard from her. Cathy told me that my insurance was put under plan one, but I was paying for plan three, and that plan one only paid $50 three times a year, so she was going to get to the bottom of it.

After not hearing from her, I called Mrs. Snyder's office to see if I could get some help.

Thank you,
S[redacted] H[redacted]

Simple Health

Health Benefits One

Response

September 24, 2018

State of Pennsylvania
Department of Insurance

COMPLAINT RESPONSE

Re: S[redacted] H[redacted]
File Number: 18-122-229032

To Whom It May Concern:

Please allow this letter to serve as a formal response to an inquiry from the State of Pennsylvania Department of Insurance regarding a membership with ACUSA: a Legion Limited Indemnity plan underwritten by AXIS Insurance Company for S[redacted] H[redacted] (who will be referred to as the member throughout this response).

January 30, 2017, member did a needs and cost analysis to find a suitable product. During the pre-qualifying stage, the member was asked to state any pre-existing conditions. Once paired with a product, the member was then transferred to the verification department for a voice verification with the details of the product and/or products they chose to purchase. This is done for the protection of the member to ensure their understanding of purchase.

Simple Health

Member was advised of the overview of the Benefits, Association and First Health Network, Limitations & Exclusions and Security & Privacy which are available immediately for their viewing by going www.hiquote.com. HBO further advised the member to review the policy and certificate for a list of any exclusions, limitations and acknowledgements specific to their state.

Per the member's complaint form, the member stated he was misinformed about which plan he was covered under and was denied benefits. During the enrollment process the member was advised the plan he was enrolling into was plan 1, which was the only plan that was available at the time of enrollment he was never offered any other plan. The member was advised plan 1 is a limited medical plan, if he was to receive services from an in-network provider or facility. The member could be eligible to receive any applicable contracted rates and may also be eligible for a cash indemnity benefit as listed on the schedule of benefits provided. The member acknowledged and agreed to all terms and conditions of the policy.

Please be advised Heath Benefits One, LLC does not handle claims.

Should you have any additional questions regarding this, please feel free to contact our Compliance Department at 1-800-492-1834.

Sincerely,

Robert Siegel

D[redacted] A. H[redacted]
S[redacted] G. H[redacted]
[redacted]
Montello WI. [redacted]
[redacted]

OCT 02 2017

[redacted]

OCT 02 2017

9/25/17

Unified Life Insurance PO Box 25326 Overland Park KS 66225-5326

Grievance Letter;

Dear To whom it concerns,

This letter is in regards to the Explanation of Benefits we received in the mail regarding the date 07/17/2017 in the amount of $13,347.40 .
The reason you gave for not covering the date in question is;
"The charge incurred during 30 day waiting period."
First I would like to point out that this letter is being written after sitting on the telephone, on hold for **54 minutes**, with NO ANSWER, from **anyone** in your Customer Service Department.
When we first got your policy we were told by a Laya Leigh Lusignan, that it would be effective and ready to use on 7/16/17.
It Also states very clearly in the Policy Certificate that I am covered under your insurance on page 4 and I quote;
Covered Sickness: A Covered sickness means a sickness which:
* occurs **after** the certificate effective date shown on the certificate Schedule;
* occurs while this certificate is in force; and
* is not excluded by name or specific description in this certificate.

Eligibility And Effective Date:
Your coverage under the policy will start at 12:01 am standard time on the Certificate Effective Date shown on Your Certificate Schedule. (7/16/17)

This means that it is under my understanding that the day in question was and will be covered by you! There was Never any mention of a 30 day waiting period, that has been given as your reasoning for nonpayment of the bill in question. And there are other bills that you did pay, that are before the date of the bill in question. So as you can certainly see this grievance letter was logically my first step in actions.
I would urge you to please take the necessary steps forward to relive the distress in this matter, so we may continue to have an ongoing relationship.
Thank you.
Sincerely [redacted]

Health Benefits One

Response

October 04, 2017

COMPLAINT RESPONSE

Re: D[redacted] H[redacted]

To Whom It May Concern:

Please allow this letter to serve as a formal response to an inquiry from Unified Health One regarding a membership with National Congress of Employers Association; a Unified Health One Limited Benefit Medical Plan underwritten by Unified Insurance Company for D[redacted] H[redacted] (who will be referred to as the member throughout this response).

July 16, 2017, member did a needs and cost analysis to find a suitable product. During the pre-qualifying stage, the member was asked to state any pre-existing conditions. Once paired with a product, the member was then transferred to the verification department for an EchoSign packet with the details of the product and/or products they chose to purchase. This is done for the protection of the member to ensure their understanding of purchase.

Member was advised of the overview of the Benefits, Association and Multiplan Network, Limitations & Exclusions and Security & Privacy which are available immediately for their viewing by going www.hiiquote.com. HBO further advised the member to review the policy and certificate for a list of any exclusions, limitations and acknowledgements specific to their state.

Please be advised Health Benefits One, LLC does not handle claims.

Should you have any additional questions regarding this, please feel free to contact our Compliance Department at 1-800-492-1834.

Please be advised Leigh Luisgnan is no longer with All Web Leads. Please accept this on behalf of myself as the Chief Compliance Officer

Sincerely,

C. Girouard

C. Girouard

Description of Problem

January 2017 was the first time I needed to buy my own health insurance. Previously I was always covered by my employer or by my university.

I called into Covered CA, and once I did that, my phone got blown up with dozens of phone calls from insurance providers.

I was connected to a company called HII (Health Insurance Innovations). I spoke with an agent from "Simple Health" Named Charles. I told him specifically that I was searching for an affordable PPO plan, and that I wanted personal health and dental insurance.

Charles said they had one at cheaper price that what I had seen so far, (roughly 300/month) offering a low deductible and low premium, which I should have known was too good to be true. Foolishly, I enrolled into the plan, which became effective February 2017.

The plan is called a "Legion Limited, Plan 1", underwritten by "Axis Insurance", with a Member #ALM003708. The agent I spoke with is from "Simple Health." HII (Health Insurance Innovations) is the company listed on my insurance card and the place I log into to see my plan.

Later in the year, I was surprised that my plan did not cover a couple routine medical visits and one dental visit. I called into HII and was told that my plan was not a PPO plan, rather it was a limited medical plan, which only offers small benefits (100/day for over night hospital stays, and 50/doctor visit for a few times a year). The plan is not covered under the ACC and will not product a 1099, which will likely cause me to be assessed a tax penalty

I called Simple Health directly (954-416-3670) and tried to reach a Charles, eventually spoke to customer service supervisor named Francisco. He told me that my agent's name was actually Clifford Belton. My call ticket number was (00929034). He reiterated that my agent was licensed, but he would not provide his license number.

Expected Resolution

I have paid nearly 600 dollars in medical bills that were not covered, and I am worried that I will be assessed a tax penalty for not having a plan covered by the ACA. The optimal outcome is to file a formal complaint and make sure that Simple Health is being investigated for insurance fraud -- I see multiple complaints online already. I also would like to be guided on whether any tax exemptions are possible for me, in the event that I am assessed a penalty for not having a plan covered under ACA. I just signed up for a real PPO plan under Blue Shield, which goes into effect 1/2018.

Health Benefits One

Response

December 28, 2017

State of California
Department of Insurance

COMPLAINT RESPONSE

Re: A[redacted] K[redacted]
Case Number: 8125495

To Whom It May Concern:

Please allow this letter to serve as a formal response to an inquiry from the State of California Department of Insurance regarding a membership with ACUSA: a Legion Limited Indemnity plan underwritten by AXIS Insurance Company for A[redacted] K[redacted] (who will be referred to as the member throughout this response).

February 02, 2017, member did a needs and cost analysis to find a suitable product. During the pre-qualifying stage, the member was asked to state any pre-existing conditions. Once paired with a product, the member was then transferred to the verification department for an EchoSign packet with the details of the product and/or products they chose to purchase. This is done for the protection of the member to ensure their understanding of purchase.

Member was advised of the overview of the Benefits, Association and First Health Network, Limitations & Exclusions and Security & Privacy which are available immediately for their viewing by going www.hiiquote.com. HBO further advised the member to review the policy and certificate for a list of any exclusions, limitations and acknowledgements specific to their state.

Per the member's complaint form, the member stated she needed to purchase a health insurance policy covered under ACA. It must be stated, during the enrollment process it was discussed with the member this did not meet the Affordable Healthcare Act guidelines, but rather a limited medical benefit plan which provided a cash benefit. As part of the ACUSA association, the member was advised she could receive in-network re-pricing for any applicable procedure within the network. The member also acknowledged and agreed to the terms and conditions of the policy during the enrollment process.

The member further stated she spoke with Charles but a customer service agent advised her she spoke with Clifford, then refused to give her his license number. Please be advised the members Agent of Record was Charles Rosenfeld, the customer service agent mistakenly said Clifford was the agent whom the member spoke with. Customer service agents does not have access to providing license numbers for the agents.

Please be advised Health Benefits One, LLC does not handle claims.

Should you have any additional questions regarding this, please feel free to contact our Compliance Department at 1-800-492-1834.

Please be advised Charles Rosenfeld is currently out of the office sick with the Flu. Please accept this on behalf of myself as the Chief Compliance Officer.

Sincerely,

C.Girouard

C.Girouard

Simple Helth completly sold me health insurance by miss informing me of benefits. They told me I was covered under PPO and gave me a list of information that stated I would pay $20 to $40 for doctor visit. RRX $4 to $12 generic drugs or $15 to $30 for name brand. ER visit $25 to $50. I would pay 30% to hospital and them 70%. They said I even had dental and eye care coverage. The list goes on. They claimed they could offer me this coverege at a price of $969.99 month. Once I recieived the actual policy it was not at all as they stated. (completly falsied). It was not even a qualified ACA policy.

Characters Remaining:3398

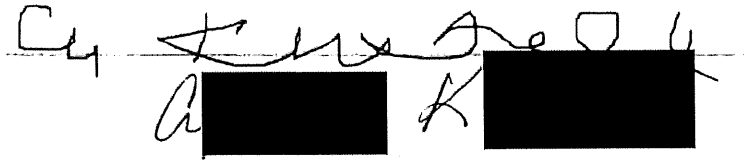
How did you hear about us? Other

Authorization Release

Insurance Department is authorized to send a copy of this document(s) to any company or agency involved. I authorize the release of all relevant information to the North Carolina Department of Insurance for its use in the review of this matter. Please note that consumer complaints become public records in accordance with applicable laws.

Please use your mouse to sign your signature in the box below

- Clear



Date: 12/04/2017

Print Form | Continue...

Simple

Health Benefits One

Response

January 12, 2018

State of North Carolina
Department of Insurance

COMPLAINT RESPONSE

Re: C[redacted]K[redacted]

To Whom It May Concern:

Please allow this letter to serve as a formal response to an inquiry from the State of North Carolina Department of Insurance regarding a membership with Health Care USA+; a Protector 360 Limited Medical Indemnity plan underwritten by Humana Insurance Company for C[redacted]K[redacted](who will be referred to as the member throughout this response).

November 15, 2017, member did a needs and cost analysis to find a suitable product. During the pre-qualifying stage, the member was asked to state any pre-existing conditions. Once paired with a product, the member was then transferred to the verification department for an EchoSign Packet with the details of the product and/or products they chose to purchase. This is done for the protection of the member to ensure their understanding of purchase.

Simple Health

Member was advised of the overview of the Benefits, Association and Humana Network, Limitations & Exclusions and Security & Privacy which are available immediately for their viewing by going www.hiiquote.com. HBO further advised the member to review the policy and certificate for a list of any exclusions, limitations and acknowledgements specific to their state.

Per the member's complaint form, the member stated she was misled to believe she was purchasing an insurance policy with co-pays for hospital, and doctor visits, as well as prescriptions. During the enrollment process, the member was specifically advised this policy has no copays, rather a contracted rate, which varies depending on each procedure or visit. When the member was discussing RX, the member was told about the different programs Simple Health utilizes such as Goodrx, Prescription Hope, and Pharmacy Checker. The member also was advised of the Target and Walmart $4 generic RX list, which provides certain medications for $4 - $10.

Please be advised Simple Health does not have an agent by the name Mario Marino. The member spoke with the agent Andrew Stromfeld. Mario may have been from the marketing company whom the member may have spoken with.

Should you have any additional questions regarding this, please feel free to contact our Compliance Department at 1-800-492-1834.

Sincerely,

A Stromfeld

Andrew Stromfeld

Details of Complaint

Description:

On March 24, 2016 I spoke to Health Insurance Innovations about obtaining a health insurance policy for myself, my husband, and infant. I made it very clear to the agent that what I was looking for in a health insurance policy was coverage of well child visits/preventative health and immunizations (NOT subject to deductible). The agent reassured me multiple times that the plan that he was selling me through "Allied National" would cover this. This was not true. My infant son had a routine preventative care well child visit in April 2016 and received routine immunizations. He also had routine preventative care well child visit 6/20/16. The insurance plan did not cover this, as previously promised by the selling agent. I contacted Health Insurance Innovations many times to try to resolve the fact that I was lied to. When I would call, I would get bounced around from one department to the next, spending hours on hold, and often never even getting through to a real person. On some occasions, Health Insurance Innovations would transfer me to Allied National. Again, I would sit on hold for hours and never got to speak to a real person. On many occasions, I contacted Allied National via phone messages and email. The automated response would promise that an agent would contact me within 24hours, however, I was never called or emailed back regarding the issue. This has been going on for many months. Had I known that this insurance company did not cover these things, I would have chosen a different company in the first place.

Resolution:

I was lied to and mislead by Health Insurance Innovations, and I was completely ignored by Allied National. Therefore, it is only fair that all the costs incurred by the routine preventative care well child visit and immunizations on 4/1/16 ($591.47) and the routine preventative care well child visit on 6/20/16 ($123.89) to be reimbursed to me, as the selling agent promised me that they would be.

Health Benefits One

Response

August 30, 2016

State of Wisconsin
Department of Financial Services
ATTN: Lisa Brandt
Insurance Investigator
Consumer Affairs Division

COMPLAINT RESPONSE

Re: A[redacted] L[redacted]
Tracking Number: 324629

To Whom It May Concern:

Please allow this letter to serve as a formal response to an inquiry from the State of Wisconsin Office of the Commissioner of Insurance regarding a membership with MSGA; a 1st Med Short Term Major Medical plan underwritten by Companion Life Insurance Company for A[redacted] L[redacted] (who will be referred to as the member throughout this response).

March 24, 2016, member did a needs and cost analysis to find a suitable product. During the pre-qualifying stage, the member was asked to state any pre-existing conditions. Once paired with a product, the member was then transferred to the verification department for an EchoSign Packet with the details of the product and/or products they chose to purchase. This is done for the protection of the member to ensure their understanding of purchase.

Member was advised of the overview of the Benefits, Association and Multiplan Network, Limitations & Exclusions and Security & Privacy which are available immediately for their viewing by going to www.hiiquote.com. HBO further advised the member to review the policy and certificate for a list of any exclusions, limitations and acknowledgements specific to their state.

During the Echosign Verification Process the member must sign and agree to the terms of the policy, which includes that well baby care visits are not covered.

Should you have any additional questions regarding this, please feel free to contact our Compliance Department at 1-800-492-1834.

Please be advised Gina Roccasalvo is no longer with Health Benefits One, LLC. Please accept this on my behalf as the chief compliance officer.

Sincerely,

C. Girouard

C. Girouard

Legion Lim Med
0015399784

O'KOON HINTERMEISTER PLLC
ATTORNEYS AT LAW

September 18, 2017

Axis Insurance Company
994 Old Eagle School Rd, Ste 1005
Wayne, PA 19087-1802

Re: Mr. R[redacted] M[redacted]
Our File No.: 170261
Your Claim No.: 01200239-02
Group Name: Legion Limited Medical

To Whom It May Concern:

This firm has been contacted by Mr. R[redacted] M[redacted] regarding the enclosed Explanation of Benefits and the above-referenced claim. Mr. M[redacted] reports that he was completely blindsided when he received this document. He tells us that he was assured, multiple times and in no uncertain terms by your sales representative, that his health insurance plan would cover emergency room visits. Much to the disappointment of Mr. M[redacted] he now discovers that his policy offers absolutely no coverage.

On his behalf, we request that you investigate this matter, including a thorough review of and recorded phone communications with Mr. M[redacted] You may send written confirmation of your corrective action to our address, shown below.

Very truly yours,

Ted Palmer

TJP/mem
cc: R[redacted] M[redacted]
enclosure

RECEIVED
SEP 21 2017
ACI

500 W. Jefferson St. | 2210 PNC Plaza | Louisville, KY 40202 | Tel: 502.581.1630 | Fax: 502.581.1821
INDIANAPOLIS | LOUISVILLE
OKOONLAW.COM

170261

Page 1 of 1

J81F [13,943] 1 of 1

Axis Insurance Company
Administrative Concepts, Inc.
984 Old Eagle School Rd Ste 1005
Wayne PA 19087-1802

Forwarding Service Requested

**********ALL FOR AADC 377
13943 1 AB 0.403 57
R [redacted] M [redacted]
[redacted]
LONDON KY [redacted]

Explanation of Benefits

RETAIN FOR TAX PURPOSES
THIS IS NOT A BILL

Customer Service Information

Questions? Please contact Customer Service at (610)293-9229
Or visit us online at www.visit-aci.com
or email us at aciclaims@visit-aci.com

Enrollee: R [redacted] M [redacted]
Date: 09/05/2017
Group Name: LEGION LIMITED MEDICAL

Claim#: 01200239-02
Patient: N [redacted] M [redacted]

Patient: MK00362470
Provider: SAINT JOSEPH LONDON

Dates of Service	Service Code	Total Charge	Ineligible Amount	Discount Amount	Other Insurance	Reason Code	Deductible Amount	Co-Pay Amount	Covered After Deductions	Paid At	Payment Amount
08/10-08/10/2017	07	$5.00	$5.00	$0.00	$0.00	LQ	$0.00	$0.00	$0.00	100%	$0.00
08/10-08/10/2017	07	$230.00	$230.00	$0.00	$0.00	LQ	$0.00	$0.00	$0.00	100%	$0.00
08/10-08/10/2017	07	$44.12	$44.12	$0.00	$0.00	LQ	$0.00	$0.00	$0.00	100%	$0.00
08/10-08/10/2017	07	$40.00	$40.00	$0.00	$0.00	LQ	$0.00	$0.00	$0.00	100%	$0.00
08/10-08/10/2017	07	$306.00	$306.00	$0.00	$0.00	LQ	$0.00	$0.00	$0.00	100%	$0.00
08/10-08/10/2017	07	$135.00	$135.00	$0.00	$0.00	LQ	$0.00	$0.00	$0.00	100%	$0.00
08/10-08/10/2017	07	$144.00	$144.00	$0.00	$0.00	LQ	$0.00	$0.00	$0.00	100%	$0.00
08/10-08/10/2017	07	$79.00	$79.00	$0.00	$0.00	LQ	$0.00	$0.00	$0.00	100%	$0.00
08/10-08/10/2017	07	$5,958.00	$5,958.00	$0.00	$0.00	LQ	$0.00	$0.00	$0.00	100%	$0.00
08/10-08/10/2017	07	$1,208.00	$1,208.00	$0.00	$0.00	LQ	$0.00	$0.00	$0.00	100%	$0.00
08/10-08/10/2017	07	$24.00	$24.00	$0.00	$0.00	LQ	$0.00	$0.00	$0.00	100%	$0.00
08/10-08/10/2017	07	$185.00	$185.00	$0.00	$0.00	LQ	$0.00	$0.00	$0.00	100%	$0.00
Column Totals		$8,369.12	$8,369.12	$0.00	$0.00		$0.00	$0.00	$0.00		$0.00
Patient's Responsibility:		$8,369.12								Total Payment Amount	$0.00

Service Code Description

07 HOSP EMER ROOM

Reason Code Description

LQ This policy does not provide benefits for services provided in the Emergency Room.

Additional Information

*** Administrative Concepts, Inc. does not share private health information except as required by law. We are committed to guarding the private information entrusted to us.

RECEIVED
SEP 21 2017
ACI

Health Benefits One

Response

October 20, 2017

O'Koon Hintermeister Attorneys at Law

COMPLAINT RESPONSE

Re: R[redacted] M[redacted]
File Number: 170261

To Whom It May Concern:

Please allow this letter to serve as a formal response to an inquiry from O'Koon Hintermeister Attorneys at Law regarding a membership with ACUSA: a Legion Limited Medical Indemnity plan underwritten by AXIS Insurance Company for R[redacted] M[redacted] (who will be referred to as the member throughout this response).

January 16, 2017, member did a needs and cost analysis to find a suitable product. During the pre-qualifying stage, the member was asked to state any pre-existing conditions. Once paired with a product, the member was then transferred to the verification department for a voice verification with the details of the product and/or products they chose to purchase. This is done for the protection of the member to ensure their understanding of purchase.

Member was advised of the overview of the Benefits, Association and First Health Network, Limitations & Exclusions and Security & Privacy which are available immediately for their viewing by going to www.hiiquote.com. HBO further advised the member to review the policy and certificate for a list of any exclusions, limitations and acknowledgements specific to their state.

Per the member's complaint form, the member stated he was misled about the emergency room coverage. The member was advised this policy was a limited medical indemnity policy, which provided a cash benefit. As part of the ACUSA association, the member was advised he could receive in-network re-pricing for any applicable procedure within the network.

Should you have any additional questions regarding this, please feel free to contact our Compliance Department at 1-800-492-1834.

Please be advised Edgardo Castro is no longer with Health Benefits One, LLC. Please accept this on behalf of myself as the Chief Compliance Officer.

Sincerely,

C. Girouard

C. Girouard

Section 4 Person completing form on behalf of Insured

First Name_____Middle Name_____Last Name_____

Address_____City, State, ZIP code_____

Best phone number where you may be reached: _____

Today's Date: (MM/DD/YY) _____/_____/_____

Signature: _____

If the person you are filing this complaint on behalf of is *over 18* please have them sign below:

"I hereby designate _____ as my authorized representative for the purposes of filing and investigating my complaint. I authorize the Consumer Protection Division of the Department of Insurance to investigate the complaint received on my behalf and to respond directly to my representative. I understand and acknowledge that by designating the individual named above as my authorized representative, the individual may obtain, on my behalf, any and all documents and information which may become known as a result of the investigation, some of which might otherwise be considered confidential. Information released to the third party may include, but is not limited to the following: Social Security numbers, personal contact information, financial information, nonpublic personal health information, medical records and any documentation included as part of the Consumer Protection investigation. Additionally, I understand and acknowledge that this third party authorization does not constitute a power of attorney and does not allow negotiation with anyone other than the actual claimant. By signing this authorization, I hereby release the Department of Insurance from any liability that might accrue from disclosing information that might be deemed confidential."

_____	_____	_____
Insured Signature	Insured Name (printed)	Date

If this person is unable to sign, please provide a copy of Power of Attorney papers or Guardianship papers.

Please use the space below to provide a **detailed** description of the problem from your point of view. Attach additional sheets if needed.

I have multiple pre existing conditions + several prescription I need filled every month. This insurance ended up not covering any pre existing conditions + the presciption card was just a discount card. They had me calling them (the insurance co.) when I needed presciptions filled so they could send me coupons to use @ different pharmacy: I have about 13 prescipts a month so they had me going back + forth to different pharmacies to get the best price and thats a lot when you have to go through all the medication every time you need one. I did go to the dermatologist while I had this Insurance Company & they had never heard of it. I really think these people were taking advantage of me because they told me that this insurance was everything I needed + it was absolutely useless.

and they definitley misrepresented themselves. I thought I was talking to a plan with Healthcare.gov. and they made the insurance plan sound like just what I was looking for. Use it anywhere in the US. No deductables, No claims. No usage, NO Referals + about $200.00 less a month than what I had been paying. I also had a deadline to get signed up so I believe they also used that against me. I have since signed up with a legit Insurance Co. that does take care of my needs. If you need anything else please dont hesitate to call. I believe this Company lied & I don't want to see them take advantage of anyone else like they did me. Thank you for your time + consideration.

M[redacted] M[redacted]
M[redacted] [redacted] M[redacted]

Health Benefits One

Response

March 5, 2018

Commonwealth of Kentucky
Public Protection Cabinet
Department of Insurance

COMPLAINT RESPONSE

Re: M[redacted] M[redacted]
File #: 2018BMB125

To Whom It May Concern:

Please allow this letter to serve as a formal response to an inquiry from the Commonwealth of Kentucky Department of Insurance regarding a membership with National Congress of Employers Association; a Health Choice + Limited Medical Indemnity plan underwritten by American Financial Security Life Insurance Company for M[redacted] M[redacted] (who will be referred to as the "member" throughout this response).

On November 22, 2017, member contacted Simple Health where she spoke with a licensed insurance agent and participated in a 'needs and cost' analysis to find the best, most suitable product. During the pre-qualifying stage, the member was asked to state any pre-existing conditions. Once paired with a product, the member was then transferred to the verification department for an Echosign Packet with the details of the product and/or

products they chose to purchase. This is done for the protection of the member to ensure their understanding of purchase.

Member was advised of the overview of the Benefits, Association and Multiplan Network, Limitations & Exclusions and Security & Privacy which are available immediately for their viewing by going www.hiiquote.com. HBO further advised the member to review the policy and certificate for a list of any exclusions, limitations and acknowledgements specific to their state.

Per the member's complaint regarding her prescription coverage, member claimed she was unware she needed to contact customer service to obtain coupons to receive the best pricing for her prescription coverage. However, when the member enrolled in the above mentioned medical plan, she was advised that her plan came *with* a Scriptpal discount card. The member was further advised of a few programs utilized by Simple Health to further assist members in lowering the cost of prescriptions, specifically "Prescription Hope", "Goodrx", and "Pharmacy Checker". Additionally, per the member's request, she was enrolled in a policy program that (i) could be used anywhere in the U.S., (ii) had no limits on usage, and (iii) required no referrals. The plan she enrolled in may have allowed her access to the contracted rate coverage available with participating providers, and the cash indemnity benefit for those services as identified in her benefits package. The member stated she went to see a dermatologist but didn't mention whether or not the provider she sought treatment from was in-network. If the provider was in-network, the member may have been eligible for the contracted re-pricing and the cash indemnity benefit of $50 for the visit.

Should you have any additional questions regarding this, please feel free to contact our Compliance Department at 1-800-492-1834.

Please be advised, Aflred Deblasio, is out of the office today with laryngitis. Please accept this on behalf of myself as the Chief Compliance Officer.

Sincerely,

C. Girouard

C. Girouard

Details of Complaint

Description:

I purchased an insurance plan from a broker who called me on my cell phone in August, 2015. I was told that the plan was comprehensive and was a great deal with a low premium and no deductible or co-pays. I explained that I had had cancer to the broker and needed coverage for another year and a half before I would become eligible for Medicare. At no point did the broker ask me if I had other coverage or explain that the plan he was selling did not constitute minimal essential coverage under ACA or that I may have to pay the health insurance mandate.

I suffered a fall and spent March 22-25 2017 in the hospital. HII has denied almost all the benefits they should pay out based on my policy and I have received over $20K in medical bills for that stay.

My daughter has researched HII and believes that they sold me my plan illegally. My policy does not contain the language it is supposed to have warning consumers that the plan is not minimal essential coverage (see point 4 (iv) in https://www.gpo.gov/fdsys/pkg/CFR-2016-title45-vol1/xml/CFR-2016-title45-vol1-sec148-220.xml)

Resolution:

I want the state of WI to start protecting consumers from brokers who sell illegal plans. According to the BBB page for HII, cease and desist orders against HII have been filed in two states (see https://www.bbb.org/west-florida/business-reviews/health-insurance/health-insurance-innovations-in-tampa-fl-90072827)

WI should follow Montana's lead in seeking restitution to insurance consumers, statutory fines, cease and desist orders, and license suspensions or revocations.

Simple Health

Health Benefits One

Response

June 19, 2017

State of Wisconsin
Office of the Commissioner of Insurance

COMPLAINT RESPONSE

Re: J[redacted]O[redacted]
File Number: 336336

To Whom It May Concern:

Please allow this letter to serve as a formal response to an inquiry from the State of Wisconsin Office of the Commissioner of Insurance regarding a membership with MSGA; a Principle Advantage Limited Medical Indemnity plan underwritten by Companion Life Insurance Company for J[redacted]O[redacted] (who will be referred to as the member throughout this response).

August 24, 2015, member did a needs and cost analysis to find a suitable product. During the pre-qualifying stage, the member was asked to state any pre-existing conditions. Once paired with a product, the member was then transferred to the verification department for a voice verification with the details of the product and/or products they chose to purchase. This is done for the protection of the member to ensure their understanding of purchase.

Simple Health

Member was advised of the overview of the Benefits, Association and Multiplan Network, Limitations & Exclusions and Security & Privacy which are available immediately for their viewing by going www.hiiquote.com. HBO further advised the member to review the policy and certificate for a list of any exclusions, limitations and acknowledgements specific to their state.

Per the member's complaint form, the member stated she was never told this plan did not meet the Affordable Car Act guidelines. Please be advised the member was advised during the enrollment process this policy did not meet the requirements. The member acknowledged and agreed this policy was not a major medical coverage plan during the verification process.

Please be advised that Health Benefits One, LLC does not handle claims.

Should you have any additional questions regarding this, please feel free to contact our Compliance Department at 1-800-492-1834.

Sincerely,

Edward Jacobs

COMPLAINT REGARDING FRADULENT HEALTH CARE & FALSE AND MISLEADING INFORMATION

Requesting Cancellation of Service and Refund from Health Insurance Innovations (HII)
Requesting Review of HII and associated companies by Illinois Department of Insurance and Illinois Attorney General

September 1, 2017

To Whom It May Concern,

Plan/ Broker: Health Insurance Innovation (HII)
Network/ Underwriter: First Health
Carrier: Axis

On July 7th, 2017 I went to the website https://www.healthcare.com/ and called the number on their site 877-626-1943 and spoke with Jeff Ross.

Jeff Ross found a "health insurance plan" for me and verbally told me the following over the phone the following information. Here is what I wrote down that day from our conversation…

The plan was supposed to:

-Be a PPO with a zero deductible

- A doctor visit would be 70% off then $50 off (I would have to wait 30 days to get 70% off, **but could go to the doctor next day after signing up and receive $50 off**)

- There would be no difference between a specialist and primary doctor

- It **included a dental plan** that would cover 50% of major work and would fully cover 3 cleanings and a set of x-rays (this would be effective next day after signing up)

- Vision- would be no cost of eye exam and 50% off of contacts

- Any hospital visits would be covered by 70% then reimbursed 50% of balance

- He asked me what prescriptions I was taking and I told him. **He then said the insurance would cover my prescriptions**

- I would be issued an insurance card through the mail and have instant access to the card online

- I could cancel the plan at any time

- The plan would mean I was exempt from the tax penalty

- I would be mailed a packet of information regarding my plan.

The monthly amount for the Health Insurance Innovation (HII) plan would be $253.57 and to sign up there was a $155.00 enrollment fee. I was then charged a total of $408.57 on my VISA-PNC credit card on 07/08/17 confirmation #981181.

I made this payment over the phone with Jeff Ross.

07/08/2017 HEALTH INSURANCE INNOVATI877-3765831 FL $408.57

(Jeff Ross said he was available for any questions or concerns in the future at ph# 800-594-4046 ex. 1603.)

After the payment he told me that I would be transferred for a verification process. He told me *just to agree* to the questions otherwise I would not receive the insurance.

I was not allowed to ask any questions during the verification process.

On July 10th, 2017 I picked up my prescriptions using my "insurance card" at Walgreens where I discovered that the plan I had purchased was **not** insurance to cover my medications, but a medical discount card.
I was lead to believe that I was purchasing an insurance plan that would cover my medications. This was a lie.
(See photograph of "insurance card" and Medical discount card.)

At some point I logged onto my account at www.hiiquote.com to change my form of payment from my PNC-VISA to TCF Bank Checking.

This is when I discovered that I was billed for "benefits" I was not aware I purchased:

PEP Benefit- approximately $155 for access to a website regarding health
RX Helpline- approximately $30+ for access to a phone number for prescription discounts
Teladoc Benefit- approximately $30+ for access to a phone number to talk with a doctor

On July 2I, 2017 I called Health Insurance Innovations to remove the PEP benefit. They said I would be refunded the money in the amount of $155.00.

On July 23, 2017 I called Health Insurance Innovations to remove the RX Helpline and Teladoc Benefit. Whomever I talked to said I would then be refunded a total amount of $233.13.
The refund would be $155 for getting rid of the PEP Benefit.
And the remaining $78.13 would be for getting rid of the RX Helpline AND the Teladoc Benefit.

This would mean my plan would be $38.14.
If I had known that this plan was only $38.14 it would have been obvious to me that this was a scam. Not revealing the actual amount of the plan was false and misleading information. The person that sold me the plan did not disclose PEP Benefit, RX Helpline or Teladoc Benefit or the cost AT ALL.

I did receive a refund in the mail, not for the $233.13 as I was promised but for $155.00. The check was from Health Plan Intermediaries Holdings LLC, HII Premium Trust ch# 7380 in the amount of $155.00.

PLEASE BE ADVISED I WILL NOT BE CASHING THIS CHECK TO AVOID FURTHER DEALING WITH HII. To prove that I will not cash the check here is of a photograph of it ripped in half with VOID written on it.

On August 23, 2017 I called HII 877-376-5831 to inquire why I was sold an "insurance plan" under false pretenses.

They told me they were the billing department and that I should talk with the company that sold me the plan. I also asked them why I was charged 3x on August 9th.

Twice on my PNC-VISA:

08/09/2017
HEALTH INSURANCE INNOVATI877-3765831 FL
$130.45

08/09/2017
HEALTH INSURANCE INNOVATI877-3765831 FL
$30.00

08/09/2017

And once on my TCF CHECKING account:
08/09/2017 in amount of $38.14

When I the HII phone number I spoke with Bane on August 23, 2017 at 8:30AM he told me:

$38.14 was for my medical plan
AND,
$130 for accidental death and dismemberment
$30 was for something else

I did not agree add on the $130 or the $30.

I was unaware of the charges and what I was being charged for. I did not give consent for these additional charges. There was no notification of the additional charges as well.

Disputed Charges and Refunds as of 09/01/17:

TCF BANK-
On August 23, 2017 I called my bank to dispute the withdrawal of $38.14 on August 9th, 2017.
I was refunded $38.14 money on 08/28/17
I called on August 30, 2017 and was informed that HII refunded the money. This has been resolved.

PNC BANK
On August 23rd I called PNC- VISA and spoke with Evan from the dispute department to dispute the following charges:

08/09/2017
HEALTH INSURANCE INNOVATI877-3765831 FL $130.45
CASE# 1201723500188

08/09/2017
HEALTH INSURANCE INNOVATI877-3765831 FL $30.00
CASE# 1201723500187

and the initial charge of

7/08/2017
HEALTH INSURANCE INNOVATI877-3765831 FL $408.57
CASE# 1201723500186

I was refunded this on my PNC VISA
08/23/2017
FINANCE CHG DISPUTE ADJ
-$28.63
I called on August 30, 2017 and was informed that PNC refunded money for interest on disputed charges.

HII REFUND CLAIMS:
On 08/25/17 I received multiple emails from HII stating I was refunded money in the amount of $130.45, $30.00, and $38.14.

This is misleading because I was only refunded $38.14 to my checking account.

Complaint

I should not have been sold a plan by a broker that is NOT licensed in the State of Illinois.

I was told false and misleading information to convince me to purchase a plan.

I did not know I was purchasing the PEP benefit, RX helpline, or Teladoc benefit.

I was unaware of these additional charges to my credit card:
08/09/2017 $130.45 and 08/09/2017 $30.00

I was lied to about an **insurance** card covering my prescriptions.

I was lied to about the plan being a PPO.

I was lied to about the medical coverage.

I am concerned what this company will do with my personal and private information.

I am concerned that they will not cancel this plan.

I am now paying for my medical bills and medication all out of pocket.

I never received a packet in the mail concerning the details of the plan as I was promised.

I now have no coverage whatsoever and this entire experience has been extremely stressful and time consuming.

Under the Affordable Care Act I am now subject to tax penalty.

I have called HII and First Health many times regarding questions and cancellation. The information I receive differs person to person and I have been transferred many times to extensions that do not exist. I have also been told that, "managers will call me back" but I have not once received a phone call back.

A quick Google search reveals there have been multiple complaints against this company. **HII and other associated companies should not be in business and I am afraid for other consumers.**

Sincerely,
N[redacted] P[redacted]
[redacted]
Park Ridge, IL [redacted]
[redacted]

Health Benefits One

Response

September 22, 2017

State of Illinois
Department of Insurance

COMPLAINT RESPONSE

Re: N[redacted] P[redacted]
File Number: IL17-10195

To Whom It May Concern:

Please allow this letter to serve as a formal response to an inquiry from the State of Illinois Department of Insurance regarding a membership with ACUSA: a Legion Limited Medical Indemnity plan underwritten by AXIS Insurance Company for N[redacted] P[redacted] (who will be referred to as the member throughout this response).

July 07, 2017, member did a needs and cost analysis to find a suitable product. During the pre-qualifying stage, the member was asked to state any pre-existing conditions. Once paired with a product, the member was then transferred to the verification department for a voice verification with the details of the product and/or products they chose to purchase. This is done for the protection of the member to ensure their understanding of purchase.

Member was advised of the overview of the Benefits, Association and First Health Network, Limitations & Exclusions and Security & Privacy which are available immediately for their viewing by going to www.hiiquote.com. HBO further advised the member to review the policy and certificate for a list of any exclusions, limitations and acknowledgements specific to their state.

Per the member's complaint form, the member stated she was misled about the coverage. The member stated she was told by her agent a doctor's visit would be covered at 70% then $50 off the total amount. The member was advised this policy was a limited medical indemnity policy, which provided a cash benefit. As part of the ACUSA association, the member was advised she could receive in-network re-pricing for any applicable procedure within the network.

The member stated she was advised her plan included a dental and & vision plan which covered 50% off all services. The dental savings plan on average offers a savings from 20%-50% off on most dental care procedures. EyeMed Vision Care Access Plan offers a savings of 20% to 40% off vision exams and eyewear with more than 50,000 providers nationwide.

Furthermore, the member went to pick up her prescription and tried using her card but discovered it was a discount card. During the enrollment process, she was informed she has a discount ScripPal prescription card,which allows her to receive an average of 46% discounts on her RX needs. In addition, by calling our customer service department to go over options for her prescriptions needs through goodrx, prescription hope, and pharmacy checker. that allows us to send her vouchers for all her prescription needs.

After further review by Health Benefits One, LLC no one named Jeff Ross works for and / or contracted with our organization.

Should you have any additional questions regarding this, please feel free to contact our Compliance Department at 1-800-492-1834.

Please be advised Larry Thomas (license #9719306) is no longer with Health Benefits One, LLC. Please accept this on behalf of myself as the Chief Compliance Officer.

Sincerely,

C. Girouard

C. Girouard

Description of Problem

In 2015 I got health insurance through a company called unified Life. In december of 2015 I had an emergency bypass. I have tried in vane to get a hold of someone in this insurance company but was put off every time. We now have a $350,000 medical bill we cannot pay. We are of retirement age and don't have this kind of money. We can't possibly pay this bill, we need someone to help us. I was never sent a contract or do I have anything regarding this insurance company. Please help us. Thankyou for your time D[redacted]S[redacted]

Expected Resolution

At least some kind of lower bill that we could pay by the month

Documents Uploaded? N

Primary Language at Home English

Race/Ethnicity White

Full Name D[redacted]S[redacted] Date Submitted 13-APR-17

Health Benefits One

Response

August 8, 2017

State of California
Department of Insurance

COMPLAINT RESPONSE

Re: D[redacted]
File Number: RUS- 7165334

To Whom It May Concern:

Please allow this letter to serve as a formal response to an inquiry from the State of California Department of Insurance regarding a membership with NCE; a Unified Health One Limited Medical Indemnity plan underwritten by Unified Life Insurance Company for D[redacted]S[redacted] (who will be referred to as the member throughout this response).

June 23, 2015, member did a needs and cost analysis to find a suitable product. During the pre-qualifying stage, the member was asked to state any pre-existing conditions. Once paired with a product, the member was then transferred to the verification department for a Voice Verification with the details of the product and/or products they chose to purchase. This is done for the protection of the member to ensure their understanding of purchase.

Member was advised of the overview of the Benefits, Association and Multiplan Network, Limitations & Exclusions and Security & Privacy which are available immediately for their viewing by going www.hiiquote.com. HBO further advised the member to review the policy and certificate for a list of any exclusions, limitations and acknowledgements specific to their state.

Please be advised Health Benefits One, LLC does not handle claims.

Should you have any additional questions regarding this, please feel free to contact our Compliance Department at 1-800-492-1834.

Please be advised Gina Roccasalvo is no longer with Health Benefits One, LLC. Please accept this on behalf of myself as the Chief Compliance Officer.

Sincerely,

C. Girouard

C. Girouard

May 04, 2017

Consumer Protection Agency

Louisiana Office of the Attorney General

P O Box 94005

Baton Rouse, LA 70804

To Whom It May Concern:

I'm writing this not knowing if you can help me or not. However, if you get enough complaints from other victims like myself, an investigation may be warranted.

My wife passed away recently. Although not in health insurance, she was in the insurance industry for over 30 years. I was included in her health insurance policy through Blue Cross. She always handled our health insurance. When she suddenly passed away, I was forced to obtain my own health insurance. I admit I lack experience in this area since my wife always handled it. At the time, I did not ask the right questions while searching for health insurance.

I Googled health insurance. And I spoke with a representative who had the "perfect plan" for me. Identical to the same plan I had with Blue Cross. Individual health plans were expensive. But this was a group plan - with millions of policy holders. Hence the reason the rate was just under $300/month. This is not Obama Care. So, I purchased this policy in July 2016 and had the monthly bill automatically deducted from my checking account. Policy was with Companion Life. Policy # CL[redacted]

I am a healthy person. I do my yearly checkups with various doctors. I haven't been to an emergency room (ER) in over 35 years. In October 2016, my Labrador Retriever cut in front of me and broke my little toe on my left foot. There is a hospital directly across the highway from me, less than 5 minutes away: Lakeview Regional Medical Center. So, I hobbled over there, gave them my insurance card, and was admitted. I spent about 3 hours having my toe repaired, and went home.

About 60 days later, just before I received the bills for my toe, I was awakened in the middle of the night in great pain. I thought I was having an appendicitis attack. So, I had a friend rush me over to the same hospital since it was the closest to my home. Turns out I was passing a kidney stone. I spent about 5 or 6 hours at the hospital, passed the stone, and went home. I haven't been to an ER in over 35 years, and unfortunately, I had to go twice in a short period of time.

A few days after passing the stone, I started receiving the bills for my toe. A doctor bill for $942, and an ER bill for $1,622.81. How much did this "perfect plan" reimburse the hospital for? $50. Why? I called and was informed that my policy didn't cover ER. Excuse me? This was never explained to me. Then I got the bill for the kidney stone: $14,563.93 (that's another story for another day). And staying in true form, Companion Life only paid $50. So, with bills amounting to $17,000, my insurance company only paid $100. Do I expect Companion Life to pay the bill in full? Of course not. But who in their right mind

would purchase a policy that would not include ER? I would have not even considered this policy had this fact been explained to me at the time of purchase.

I called all parties associated with this policy: Companion Life, WEB-TPA, Health Insurance Innovations, Multi Plan Network, and Mid-Sense Guaranteed Association. Every time I called someone, I was told I was talking to the wrong party and given another number to call. Everyone kept shifting blame. Call after call. One lady in claims told me there was nothing they could do since this was the plan I agreed to purchase. I told her the three doctors involved with both ER visits were included in their list of preferred doctors. But since they were ER visits, they were not covered. The doctors are approved as preferred doctors, but Companion Life will not honor the claim. I explained to her this plan was not the plan that was explained to me, but my concerns were ignored. This plan is not worth the paper it's written on.

As I mentioned earlier, I now know what questions to ask. I'm confident the man who sold me this policy was well trained to say whatever is necessary to sell a policy and meet his quota. Regardless of the consequences suffered for the policy holder down the road. He sleeps well at night, and I have no idea how I'm going to come up with $17,000 to pay my bill.

I strongly feel Companion Life, WEB-TPA, Health Insurance Innovations, Multi Plan Network, and Mid-Sense Guaranteed Association are nothing but sharks in suits. I was completely misinformed and taken advantage of. If I know of anyone seeking health insurance to avoid these companies at all cost.

Sincerely

R[redacted]S[redacted]

[redacted]

Mandeville, LA[redacted]

cc:

(1) Lakeview Medical Center, P O Box 402840, Atlanta, GA 30384-2840
95 Judge Tanner Dr, Covington LA 70433
(2) HCFS Healthcare Financial Services, LLC, PO Box 459077, Sunrise, FL 33345-9077
(3) WEB-TPA, P O Box 1808, Grapevine, TX 76099
(4) Multi Plan Network, 115 Fifth Ave, New York, NY 10003
(5) Health Insurance Innovations, 217 E Bearss Ave, Suite 325, Tampa, Florida 33613
(6) Mid-Sense Guaranteed Association, 917 Clocktower Dr, Suite 100, Springfield IL 62704
(7) Companion Life, P O Box 100102, Columbia, SC 29202-3102
(8) Better Business Bureau, 3421 N Causeway Blvd, Metairie LA 70002
(9) HRRG P O Box 8486, Coral Springs, FL 33075-8486

Health Benefits One

Response

May 15, 2017

State of Louisiana
Office of the Attorney General

COMPLAINT RESPONSE

Re: R[redacted] S[redacted]

To Whom It May Concern:

Please allow this letter to serve as a formal response to an inquiry from the State of Louisiana Office of the Attorney General regarding a membership with MSGA; a Principle Advantage Limited Medical Indemnity plan underwritten by Companion Life Insurance Company for R[redacted] S[redacted] (who will be referred to as the member throughout this response).

July 29, 2016, member did a needs and cost analysis to find a suitable product. During the pre-qualifying stage, the member was asked to state any pre-existing conditions. Once paired with a product, the member was then transferred to the verification department for an EchoSign Packet with the details of the product and/or products they chose to purchase. This is done for the protection of the member to ensure their understanding of purchase.

Member was advised of the overview of the Benefits, Association and Multiplan Network, Limitations & Exclusions and Security & Privacy which are available immediately for their viewing by going www.hiiquote.com. HBO further advised the member to review the policy and certificate for a list of any exclusions, limitations and acknowledgements specific to their state.

Please be advised Health Benefits One, LLC does not handle claims.

Should you have any additional questions regarding this, please feel free to contact our Compliance Department at 1-800-492-1834.

Please be advised Paul Lindsay is no longer with Health Benefits One, LLC. Please accept this on my behalf as the Chief Compliance Officer.

Sincerely,

C.girouard

C.Girouard

MARCH 27, 2016

D, V[redacted]
[redacted]
Boulder, CO [redacted]

SCAM : HiiQuote.com (INTERNET

A MAN NAMED ~~GEORGE~~
DANIEL G. & CHRISTOPHER (2ND CALL) LIED
SOLD ME THIS POLICY.
I CALLED FOR MY SON DENIS FROM THE INTERNET ADS FOR OBAMA AFFORDABLE HEALTH INS. I TASKED FOR ANTHEM BLUE CROSS HE SAID HE COULD GET ME ~~A~~ MUCH BETTER. HE GOT ME TO AGREE AND CHARGED ME $398— MASTER CARD. (FOR 1ST MO.)
WHEN I RECEIVED GOT THE EMAIL PLAN IT WAS NOT EVEN ACCEPTED FOR AFFORDABLE INS BY LAW.
IT TOOK FOREVER TO EVEN FIND THE COVERAGE WHICH WAS NOT WHAT I TOLD HIM I WANTED
THIS IS A SCAM. HE ESCAPED MY KIDS

[redacted]

MY SON DIDNOT ~~RECEIVED~~ THIS POLICY ~~BACK UP OFF~~

WE SOLD US NO AFFORABLE OBAMA HEALTH PLAN

NOW MY SON CANNOT GET INS TIL THE FALL !!!!!

BECAUSE OF THIS MAN. DANIEL G. ~~GREEN~~ HE IS UNPROTECTED HONABLE D. [redacted]

I HAVE NOTICED OTHER COMPLAINTS ABOUT THIS HIGUOTA. COM OUT OF FLORIDA.

PLEASE HOW DOES D[redacted] V[redacted] GET HEALTH INS NOW? THANK YOU

D[redacted] V[redacted]

Exhibit

HiiQUOTE.COM

THIS MAN CALLED DANIEL G.
AND A MAN CALLED (CHRISTOPHER WHEN I CALLED THEM BACK
~~[illegible] TO ME~~
SAID THIS PLAN IS BETTER
THAN BLUE CROSS!
SOLD IT TO ME A DAY BEFORE
OPEN ENROLLMENT STOPPED.
HE SAID EMERGENCY ROOM WAS COVERED
(CHRISTOPHER SAID) IT IS NOT!.
HE ~~[illegible]~~ SOLD ME A SUPPLEMENT
PLAN. — GEORGE G.
I SAID I WANTED A FULL
HEALTH INS PLAN.
I WAS DECEIVED!

[redacted] V[redacted]

MAR 28, 2017

Simple Health

Health Benefits One

Response

April 20, 2017

State of California
Department of Insurance

COMPLAINT RESPONSE

Re: L[redacted]S[redacted]
File number: RUS-7164446

To Whom It May Concern:

Please allow this letter to serve as a formal response to an inquiry from the State of California Department of Insurance regarding a membership with ACUSA; a Legion Limited Medical Indemnity plan underwritten by AXIS Insurance Company for L[redacted] [redacted](who will be referred to as the member throughout this response).

October 21, 2016, member did a needs and cost analysis to find a suitable product. During the pre-qualifying stage, the member was asked to state any pre-existing conditions. Once paired with a product, the member was then transferred to the verification department for an EchoSign Packet with the details of the product and/or products they chose to purchase. This is done for the protection of the member to ensure their understanding of purchase.

Simple Health

Member was advised of the overview of the Benefits, Association and First Health Network, Limitations & Exclusions and Security & Privacy which are available immediately for their viewing by going www.hiiquote.com. HBO further advised the member to review the policy and certificate for a list of any exclusions, limitations and acknowledgements specific to their state.

Per the member's complaint form, the member stated she was misled into believing she was sold an actual dental plan not a discount plan. Please be advised all products and benefits were fully discussed with the member during the initial enrollment process. In addition the member signed and agreed to all the terms and conditions including all limitations and exclusions during the enrollment process.

Should you have any additional questions regarding this, please feel free to contact our Compliance Department at 1-800-492-1834.

Sincerely,

Julio Bercowicz

Problem Report Information Inquiry

Problem Report ID: 45328 **Problem Report Type:** Complaint **Responsible Section:** Consumer Services

Status: Open **Opened Date:** 05-17-2018 **Closed Date:** **Closure Reason:**

PROBLEM REPORT DETAILS

TYPE OF PROBLEM	OTHER PROBLEM TYPE DESCRIPTION
Claim Denial/Delay	

DESCRIPTION

CONSUMER DETAIL OF COMPLAINT

Bought a medical insurance policy that was 70/30, $2,500 deductible. Womens health covered, no prescription coverage.
Have received no additional policy info.
Was admitted to the hospital twice for possible heart issue. They have paid $50.
I called to inguire why. They initially said it was only a supplemental policy.
Second time I called they said yes it was supplemental policy but can be used for major medical.
Asked why they hadnt picked up more than $50, they informed me they only pay for one charge a day.
Asked why I wasnt sent a written policy, they said did you get a card, told them yes, but no policy was sent.
Asked why nothing was paid for the hospital stay, they said they dont see a hospital stay.
ER was 3/13, admitted on 3/14/2018.
Asked why they didnt pay for blood work panel, they said they would only pay for one test.
Asked o speak to a supervisor, said non was available.
Asked to speak to a Hippa compliance officer, said they dont have one.
Hung up on me
Called back.
Asked to cancel my policy. Transferred me.
Asked to cancel the policy, transferred me again.
Asked to cancel my policy, said Id have to talk to a Simple Health, transferred me again.
Asked to cancel my policy, asked why, told them why, asked if my policy was canceled now, they said no, Id have to talk to a supervisor. Left on indefinite hold.
Called my credit card company to cancel the charge. Was informed that I cant cancel the charge only the insurance company can do that per the way it was set up.

CONSUMER DESIRED RESOLUTION

Hang them by their toes!!!
This policy was purchased in good faith.
I went through all questions that I thought were reasonable and gave me the information needed.
Ive had two hospital stays, one for $26,920 (just the hospital, not including the doctors charges) and the other for $27,000+ (not all bills have come in yet). I would like them to pick up their 70% for the policy I purchased in good faith.

CONSUMER IS COMPLAINING AGAINST	CONSUMER IS REPRESENTED BY AN ATTORNEY?	HOW DID THE CONSUMER KNOW ABOUT US?
My Insurance Company	No	Consumer Portal

HAS THE CONSUMER PREVIOUSLY REPORTED THIS PROBLEM TO OUR OFFICE OR ANY OTHER AGENCY?	PURCHASED INSURANCE ON THE HEALTH CARE EXCHANGE?
Yes	No

Health Benefits One

Response

June 07, 2018

State of Nevada
Division of Insurance

COMPLAINT RESPONSE

Re: K[redacted] W[redacted]
File Number # 18-TA 45328

To Whom It May Concern:

Please allow this letter to serve as a formal response to an inquiry from the State of Nevada Division of Insurance regarding a membership with National Congress of Employers Association; Unified National Health One Limited Benefit Medical Plan, underwritten by Unified Life Insurance Company for K[redacted] W[redacted] (who will be referred to as the member throughout this response).

October 13, 2017, member did a needs and cost analysis to find a suitable product. During the pre-qualifying stage, the member was asked to state any pre-existing conditions. Once paired with a product, the member was then transferred to the verification department for a voice verification with the details of the product and/or products they chose to purchase. This is done for the protection of the member to ensure their understanding of purchase.

Member was advised of the overview of the Benefits, Association and Multiplan Network, Limitations & Exclusions and Security & Privacy which are available immediately for their viewing by going www.hiiquote.com. HBO further advised the member to review the policy and certificate for a list of any exclusions, limitations and acknowledgements specific to their state.

Per the member's compliant form, the member states she was told the plan would cover her at 70%. Please be advised the member was informed the membership would offer in-network repricing of up to 70% qualifying procedures. Members are advised percentages are based upon region and CPT codes, which we cannot provide.

Please be advised Heath Benefits One, LLC does not handle claims.

Should you have any additional questions regarding this, please feel free to contact our Compliance Department at 1-800-492-1834.

Please be advised Catherine Higgs-Palmer is no longer with Health Benefits One, LLC. Please accept this on behalf of myself as the Chief Compliance Officer.

Sincerely,

C. Girouard

C. Girouard

From: Scott, Elizabeth C.
To: Gershoni, Elan
Cc: O"Quinn, Ryan; Rodriguez, Javier; michael.goldberg@akerman.com; naim.surgeon@akerman.com; Wei, Joannie; Davis, James
Subject: RE: FTC v. Dorfman
Date: Friday, March 01, 2019 10:06:43 AM

Dear Elan:

The Court's order at docket entry 83 is not an appealable order, and we therefore will not agree to a stay of the proceedings.

We are not opposed to rescheduling the PI hearing for March depending on the dates that are available on the court's calendar, because we have some significant scheduling challenges in March due to international travel and ongoing medical issues.

Best,
Libby

Elizabeth C. Scott
Staff Attorney
Federal Trade Commission, Midwest Region
230 South Dearborn Street, Suite 3030
Chicago, Illinois 60604
escott@ftc.gov
phone: (312) 960-5609
fax: (312) 960-5600

From: Gershoni, Elan <Elan.Gershoni@dlapiper.com>
Sent: Thursday, February 28, 2019 12:38 PM
To: Scott, Elizabeth C. <escott@ftc.gov>; Wei, Joannie <JWEI@ftc.gov>; Davis, James <JDAVIS@ftc.gov>
Cc: O'Quinn, Ryan <Ryan.OQuinn@dlapiper.com>; Rodriguez, Javier <Javier.Rodriguez@dlapiper.com>; michael.goldberg@akerman.com; naim.surgeon@akerman.com
Subject: FTC v. Dorfman

Libby, Joannie, and Jim,

Shortly we will file Mr. Dorfman's notice of appeal of the Court's order [D.E. 83] denying Mr. Dorfman's motion to strike the injunctive relief entered in this proceeding [D.E. 79] to resolve the threshold questions. In connection with that appeal, we will request a stay of this entire proceeding pending final resolution of the appeal. We will also ask that the district court expedite the preliminary injunction hearing to the next available hearing date in early March, as Judge Gayles offered to do at last week's hearing.

We anticipate filing the motion to stay the proceeding and expedite the preliminary injunction hearing tomorrow. As required by the local rules, this is our good faith effort to try to minimize the

potential need for the Court's intervention in this matter. Will the FTC agree to Mr. Dorfman's request for the stay so that the appeal can be resolved? If so, that may obviate the need for the Court to advance the preliminary injunction hearing to early March.

By **12:00 PM EST tomorrow**, please advise whether we can represent that the FTC agrees to staying the entire proceeding pending final resolution of the appeal. If we do not hear back from you by then we will assume that the FTC does not agree to the requested stay and will proceed accordingly.

Thank you.

Best,

Elan A. Gershoni

T +1 305.423.8567
F +1 305.675.0527
E elan.gershoni@dlapiper.com

DLA PIPER

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